

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

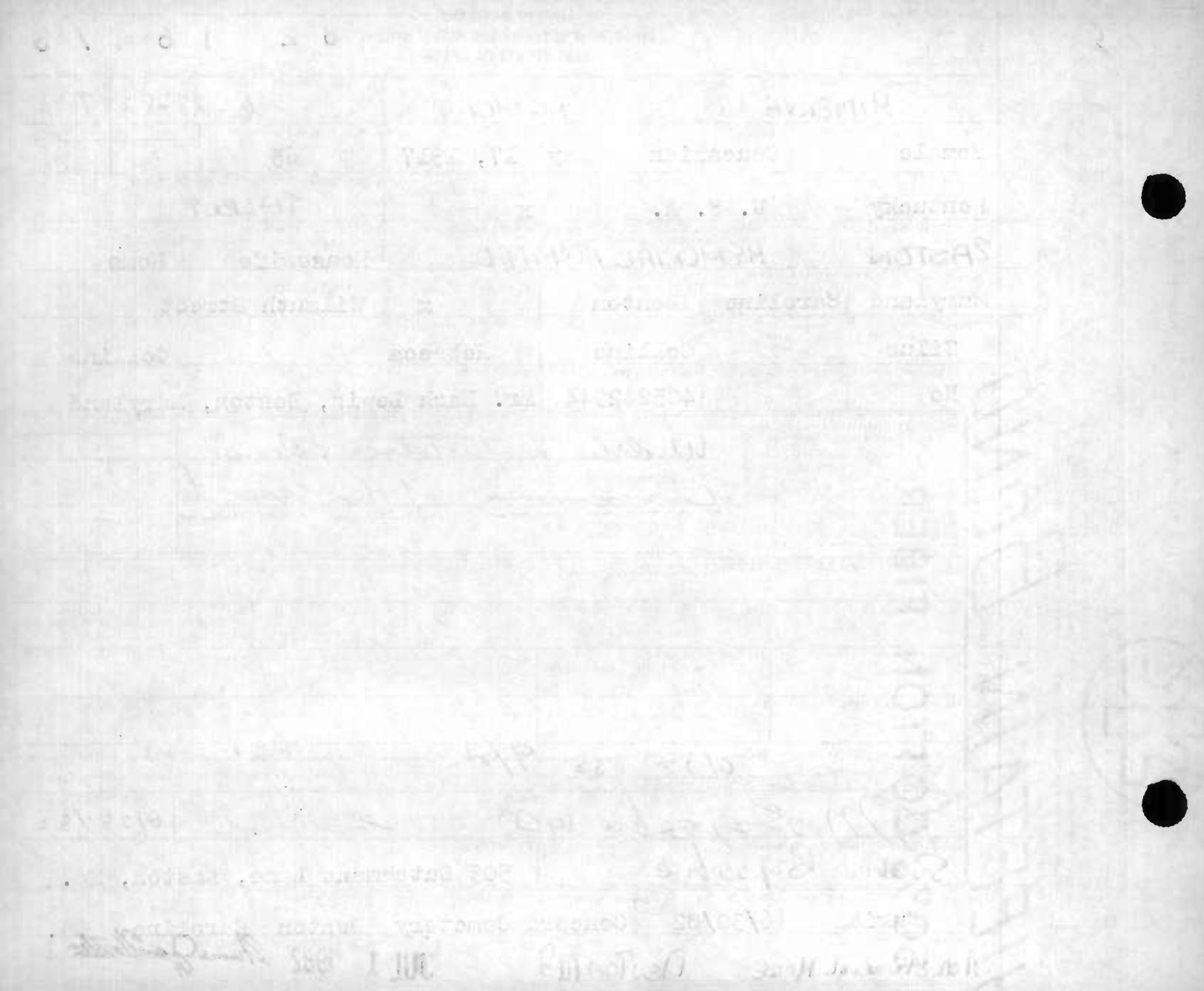
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 6 4 7 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
HINERVA					ANTHONY	6 - 28 - 82				7:05 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Caucasian		Month	Day	65	YRS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Kentucky		U. S. A.				TALBOT						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
EASTON		MEMORIAL HOSPITAL		Housewife		Home						
13a. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Maryland		Caroline		Denton		Wilmuth Street						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
		Silus		Collins	Rebecca							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		405242944		Mr. Nash Lewis, Denton, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a)		1991		Widely metastatic aden-								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Stomach								
				(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6/27/82 to 6/27/82, that (I) (we) lost sow the deceased alive on above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
S. M. Bysshe MD								6/28/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
S. M. Bysshe		505 Dutchmans Lane, Easton, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		6/30/82		Concord Cemetery		Denton		Caroline		Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR REGISTRATION AND SIGNATURE								
Mark Funeral Home		Denton Md.		JUL 1 1982		James J. Martin						

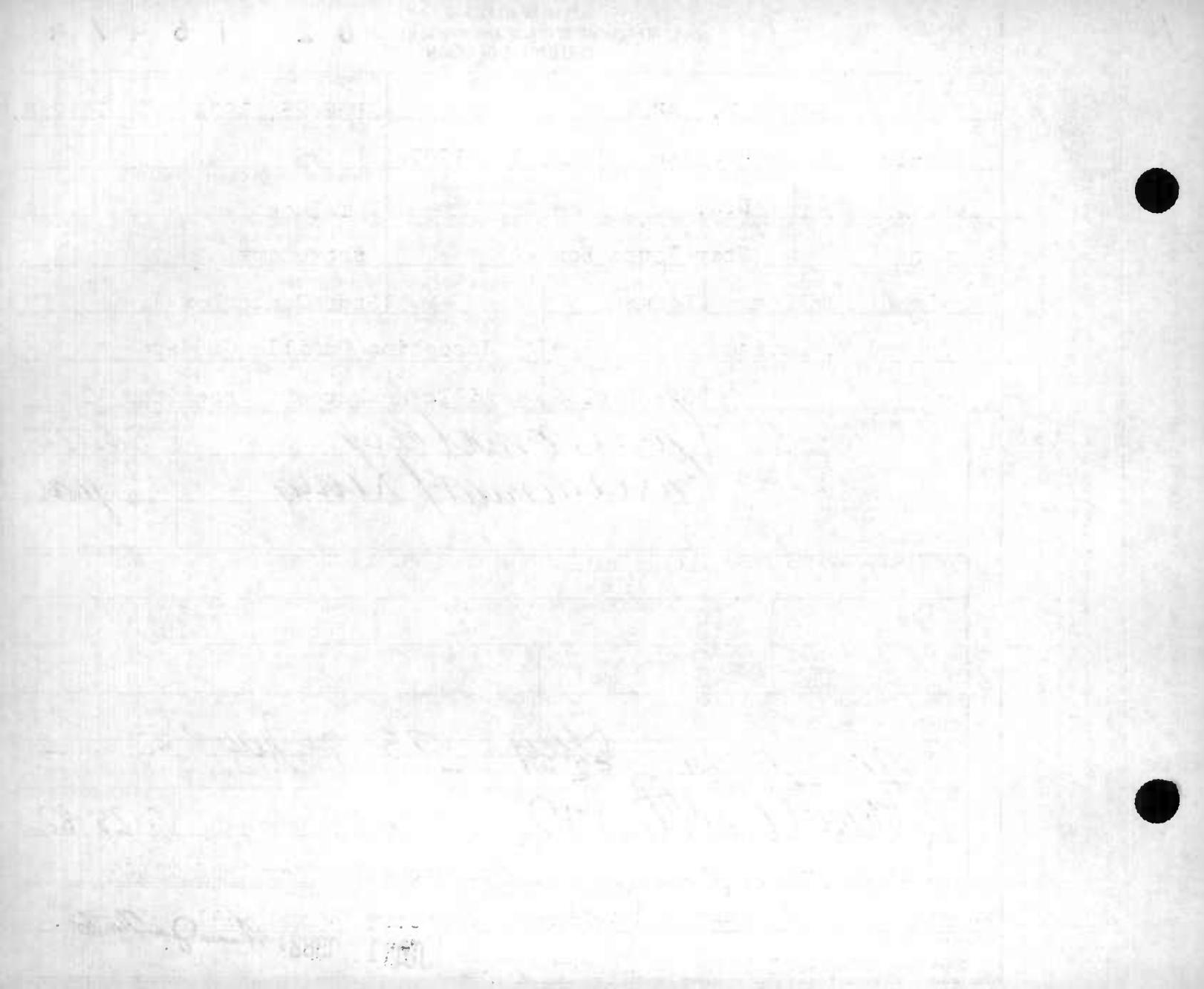


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filled in by the attending physician and completely filled in by the funeral director. Page 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the Burial Transfer Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 4 7 4				
												REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			ADAH D. ARNY						JUNE 25, 1982			12:25P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
female			caucasian			Mar. 14, 1907			75 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Penns.			U.S.						Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Bozman			Star Route Box 44			secretary										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Talbot			Bozman						Star Route Box 44				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
Richard Y. Davison			Josephine Camille Goddard			no			159-03-6155			Camille Momberger			see item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			20. DUE TO, OR AS A CONSEQUENCE OF (b)			21. DUE TO, OR AS A CONSEQUENCE OF (c)			22. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			30 days.													
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)										
21h. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			21k. CITY OR TOWN			21l. COUNTY			21m. STATE	
21n. I certify that (if this hospital) attended the deceased from now the deceased alive on 6-24 19-52 and died in (my) () opinion death occurred on the date and hour and from the causes stated above. (I am) (will) (not) (will not) view the body after death.			21o. SIGNATURE R. Lane Wroth, M.D.			21p. DEGREE MD.			21q. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			21r. DATE SIGNED 6-29-82				
21s. PHYSICIAN'S NAME (TYPE OR PRINT)			21t. ADDRESS St. Michaels, Maryland 21663			21u. ADDRESS			21v. LOCATION CITY OR TOWN Drexel Hill			21w. COUNTY Del Norte			21x. STATE	
21x. BURIAL, CREMATION, REMOVAL (SPECIFY)			21y. DATE 6-29-1982			21z. NAME OF CEMETERY OR CREMATORIAL Arlington Cemetery			21aa. DATE RECEIVED BY BURIAL TRUCK JUL 1 1982			21ab. DATE OF DEATH JUL 1 1982			21ac. SIGNATURE Newnam Funeral Home	
21b. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.													



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IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

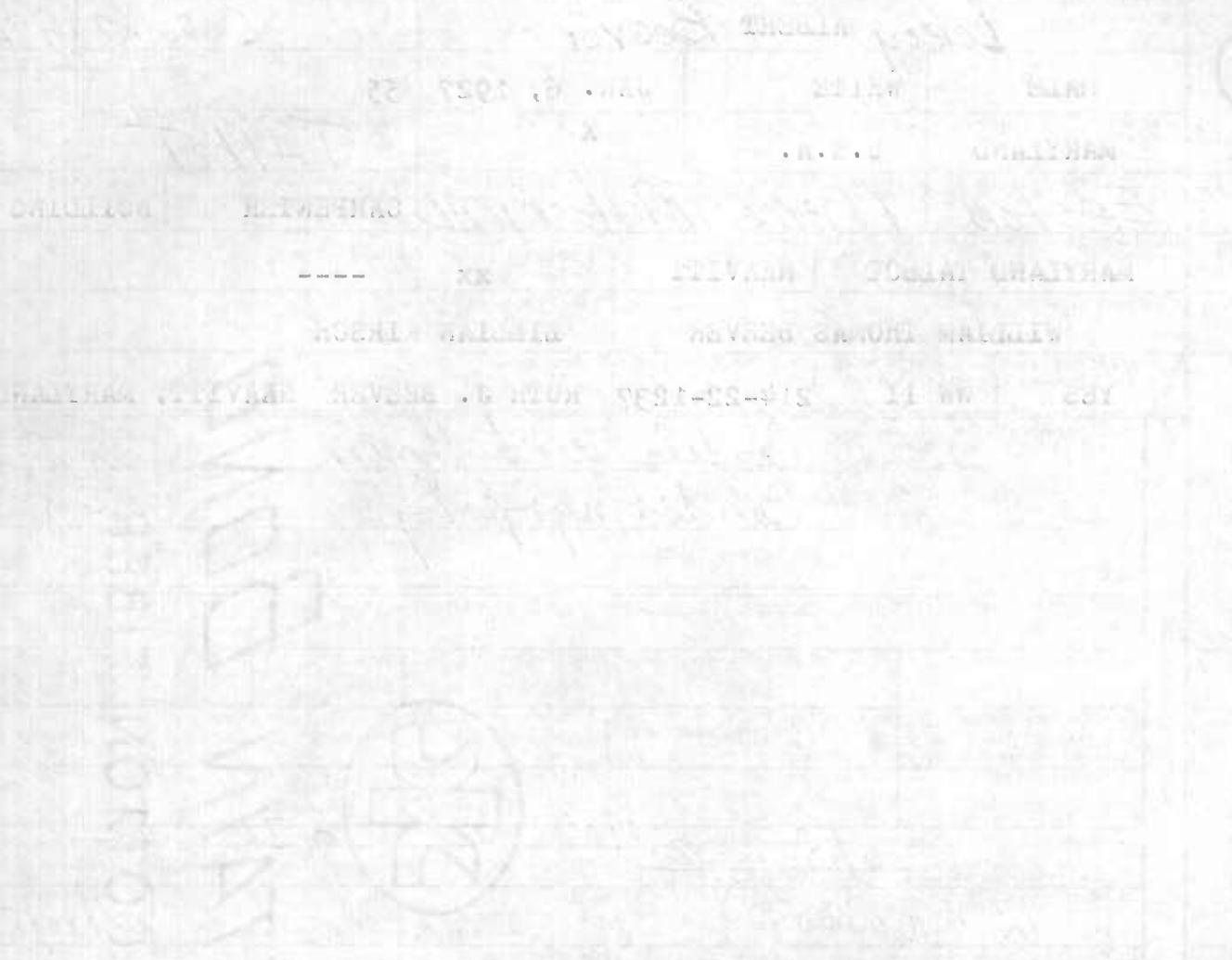
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 6 4 7 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Leroy ALBERT Beever</i>						<i>JAN. 6, 1927</i>				<i>9:30 AM</i>	
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 1 HR			
<i>MALE</i>			<i>WHITE</i>	<i>JAN. 6, 1927</i>		<i>55</i>	<input type="checkbox"/>	MONTHS	DAYS	HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>MARYLAND</i>			<i>U.S.A.</i>				<i>Talbot</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
<i>Easton</i>			<i>Memorial Hospital</i>		<i>CARPENTER</i>		<i>BUILDING</i>				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
<i>MARYLAND</i>			<i>TALBOT</i>	<i>NEAVITT</i>							
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
<i>WILLIAM THOMAS BEEVER</i>					<i>LILLIAN KIRSCH</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
<i>YES</i>			<i>WW II</i>		<i>RUTH J. BEEVER</i>		<i>NEAVITT, MARYLAND</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>Cardiomyopathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i> <i>2 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/18/82</i> , 19 <i>82</i> , to <i>6/20/82</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>6/18/82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Wm H Wood Jr</i>			22c. DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>6/20/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm H Wood Jr</i>			22e. ADDRESS <i>EASTON, MD.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 23, 1982		23c. NAME OF CEMETERY OR CREMATORIUM NEAVITT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>James E. Leonard, Ph. Michaelides</i>			ADDRESS		25. DATE REC'D. BY REGISTRAR JUN 24 1982		25. REGISTRAR'S SIGNATURE <i>Frank J. Gantner</i>				
BP _____											
DHMH - 16 50M 1/81 (VRA 15. 4)											



CHILKAT RIVER

BAKER CREEK

— — — — —

XX

PIKAN COAST CHAIN

NOON

NOON DAYLIGHT

WATER LEVEL NOON POSITION 47° 14' 00" EAT

PIKAN COAST CHAIN

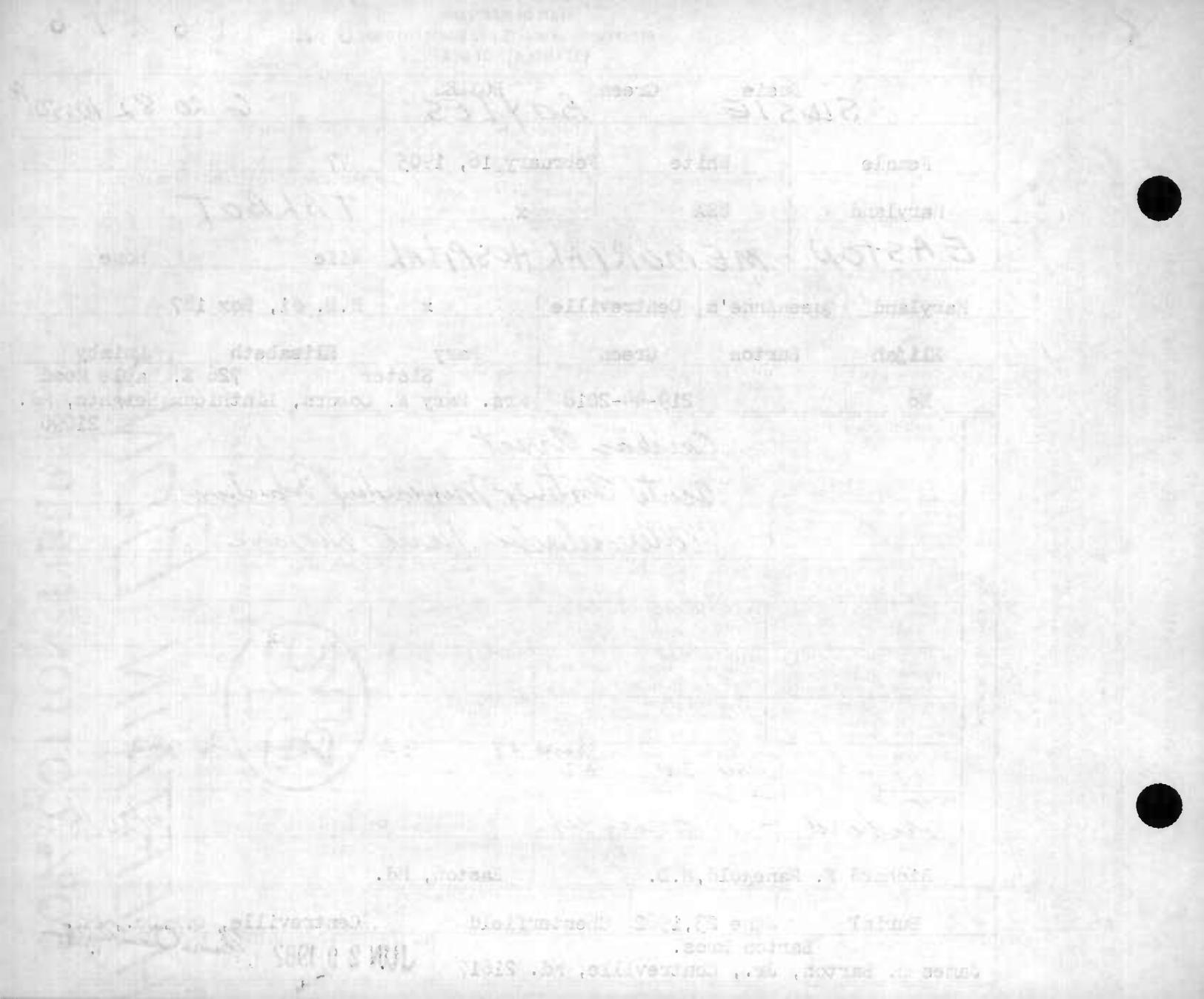
END 1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 30 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 2 1 6 4 7 6	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Susie</i>	MIDDLE <i>Green</i>	LAST <i>BOYLES</i>	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 6 20 82 10:50M				
1. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR February 16, 1905			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS				
7. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) THE STATE Maryland			13c. CITY OR TOWN Centreville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.D. #1, Box 187				
14. FATHER'S NAME FIRST Elijah			MIDDLE Burton	LAST Green	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Elizabeth	LAST Quimby				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-44-2018			17. INFORMANT Sister			ADDRESS 726 E. Maple Road				
						Mrs. Mary E. Coburn, Linthicum Heights, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anterior Myocardial Infarction						APPROXIMATE TIME BETWEEN ONSET AND DEATH 210900				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from June 17, 1982 to June 20, 1982 , that (I) (we) last saw the deceased alive on June 20, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 6/20/82	
22b. SIGNATURE <i>Richard F. Manegold</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold, M.D.			22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 23, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield			23d. LOCATION CITY OR TOWN Centreville, Q.A Co., Md.				
24. FUNERAL DIRECTOR NAME Barton Bros.			ADDRESS James H. Barton, Jr., Centreville, Md. 21617			25a. DATE REC'D. BY REGISTRAR JUN 29 1982			25b. REGISTRAR'S SIGNATURE <i>Theresa O'Neil</i>				

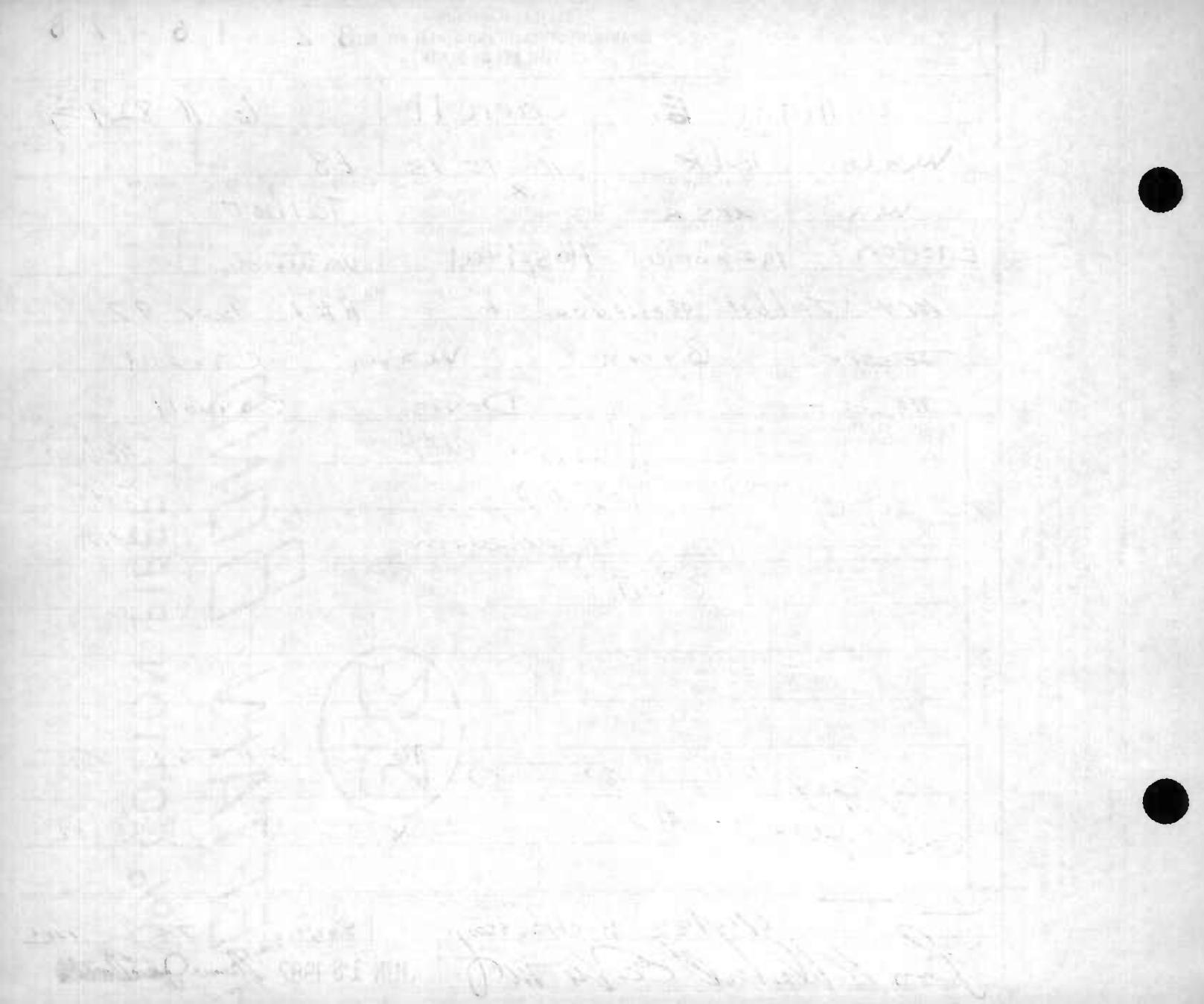


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	4	7	6
												REG. NO.						
1. FOR STATE REGISTRAR																		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR						
William E.					Carroll	6 11 82						105 PM						
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)							
Male			BLK		10 15 13						68							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. DATE OF BIRTH			IF UNDER 1 YEAR			IF OVER 14 HRS							
Md			USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			MONTHS			DAYS							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE)			12b KIND OF BUSINESS OR INDUSTRY										
Easton			Memorial Hospital		Waterson			MD										
13a STATE			13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS							
Md			Talbot		Bellevue			YES			R#1 Box 97							
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST									
Jessie				Brown	Mary					Carroll								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS										
No			-		Davis			Carroll										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
4029 IMMEDIATE CAUSE (a)			48hrs															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) ABCD															
			DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			729															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TB. PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
23. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	23e. DATE SIGNED							
<i>O'Leary MD</i>											6/11/82							
24. MEDICAL CERTIFICATION PHYSICIAN'S NAME (TYPE OR PRINT)			25. ADDRESS															
26. BURIAL, CREMATION, REMOVAL			27. DATE			28. NAME OF CEMETERY OR CREMATORIAL			29. LOCATION CITY-TOWNSHIP			COUNTY	STATE					
6/11/82			6/11/82			Richards			Easton			TN	MD					
30. FUNERAL DIRECTOR <i>For Michael E. Carroll</i>						31. DATE REC'D. BY REGISTRAR			32. REGISTRAR'S SIGNATURE									
						JUN 18 1982			<i>Theresa J. St. John</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 4 7 7				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
John C Carpenter						June 18, 1982						8:30 A.M.				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Male			B.I.K.		2 25 10			69								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		7c. DATE OF BIRTH			7d. AGE (IN YEARS LAST BIRTHDAY)			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Md.			U.S.A.					69			Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton			Memorial Hospital					Laborer			Rt. #1 Box 329A					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.			Q.A.		QueensTown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. #1 Box 329A					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						LAST				
Charlie					Carpenter	Blanche						Price				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
no			220-05-1921		William											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary unknown</u> DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/3 1982</u> to <u>6/18 1982</u> , that (I) (we) last saw the deceased alive on <u>6/7/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Johathan Hummel M.D.</u>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>6/18/82</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
Johathan Hummel, M.D.			Easton Md. 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE	
Burial			6/26/82			Carmichael			Queens Town Q.A. Md.							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
George H. Dashiell Dowtest, Easton, MD																
DHMH - 16 50M 1/81 (VRA 15, 4)																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do it.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 4 7 9
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Charles</i>	MIDDLE <i>W.</i>	LAST <i>Chester</i>	2a. DATE OF DEATH			MONTH JUN	DAY 30	YEAR 1982	2b. HOUR 9:45 AM
3. SEX Male			4. RACE White			5. DATE OF BIRTH			MONTH 6	DAY 20	YEAR 1900	6. AGE (IN YEARS LAST BIRTHDAY) 82 yrs
7a. BIRTHPLACE Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			
10. CITY OR TOWN OF DEATH Eason			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION Farmer			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Talbot			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt. 1 Box 56B			
14. FATHER'S NAME FIRST Benjamin			MIDDLE Tomczewski			15. MOTHER'S MAIDEN NAME Elizabeth			LAST Tobot			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-01-6014			17. INFORMANT Agnes Mays			ADDRESS 3206 McElderry St. Balto., MD. 21205			
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, and one cause per line for Part 2) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4100</i>			<i>Cardiogenic Shock</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24h</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any			(b) <i>Hypertension Drachan</i>									
			(c) <i>ASCVD</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) this hospital attended the deceased from <i>6/30</i> , 19 <i>52</i> , to <i>6/30</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE <i>Dr. Lewis MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/7/82</i>			
22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/6/1982			23c. NAME OF CEMETERY OR CREMATORIAL Sacred Ht. Of Jesus			23d. LOCATION CITY OR TOWN Baltimore			COUNTY Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR JUL 6 1982			25b. REGISTRAR SIGNATURE <i>Anna J. [Signature]</i>			

6808

2010

10

TNT

Small Island rocks

dark brown
soil

green grass
soil

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 4 8 0							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR							
<i>Morrison</i>			<i>P.</i>	<i>Chitterling</i>		<i>June 13 1982</i>			<i>JUN</i>	<i>13</i>	<i>1982</i>	<i>5 22 M</i>							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Male			Caucasian			NOV. 2 1898			83 YRS			New Jersey		U.S.A.			Talbot		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF INDUSTRY INDUSTRY				
<i>Easton</i>			<i>Memorial Hospital</i>									<i>Heavy Industrial Sales - equip.</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS										
Md.		Talbot		Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			501 Dutchman's Lane										
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST								
<i>Nelson</i>			<i>M.</i>	<i>Chitterling</i>		<i>Jennie</i>			<i>B.</i>	<i>Page</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
Yes			WW II			136-03-7982			Dr. Nelson M. Chitterling			Annapolis, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			BRONCITIS PNEUMONIA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			96 HOURS																
(b) CEREBROVASCULAR Accident			96 HOURS																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>6/12/82</i> , 19_____, to <i>6/13/82</i> , 19_____, that (I) (we) last saw the deceased alive on <i>6/12/82</i> , 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>C. R.W. Rain</i>			DEGREE <i>R.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/13/82</i>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. R.W. Rain</i>			22e. ADDRESS <i>Easton, Maryland.</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-17-82			23c. NAME OF CEMETERY OR CREMATORIAL Post Cemetery			23d. LOCATION CITY OR TOWN West Point Orange N.Y.			COUNTY STATE							
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JUN 16 1982			25b. REGISTRAR'S SIGNATURE <i>Newnam Funeral Home</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use or the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, this medical certification may be notified or requested.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3216481				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR June 9, 1982							2b. HOUR 6:50AM				
1. DECEASED NAME FIRST MIDDLE LAST Edna S. Collins														
3. SEX Female			4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept 9, 1893			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.						
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 207 South Seventh St.			
14. FATHER'S NAME FIRST Robert			MIDDLE		LAST Saulsbury			15. MOTHER'S MAIDEN NAME FIRST Ella			MIDDLE Lane			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220349342		17. INFORMANT Mr. Harvey Fleetwood, Denton, Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			DUE TO, OR AS A CONSEQUENCE OF (b) chronic congestive heart failure years											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 617			21f. LOCATION STREET 4128 CITY OR TOWN 19 82 to 619 COUNTY 19 87 STATE								
22a. I certify that (I) (this hospital) attended the deceased from 617 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE William J. Banfield, M.D.			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Banfield, M.D.			22e. ADDRESS 505 Dutchmans La., Easton, Md. 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/12/82		23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery			23d. LOCATION CITY OR TOWN Denton			23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Ronald P. More Deafar, M.C.			ADDRESS			24b. DATE JUN 21 1982			24c. SIGNATURE					
DHMH-16 30M 2/80 (VRA 15, 4)														

SBT 1980

red kaF

subversive and now at point

of the

the non-violent struggle

SBT 1980

© 3M Company

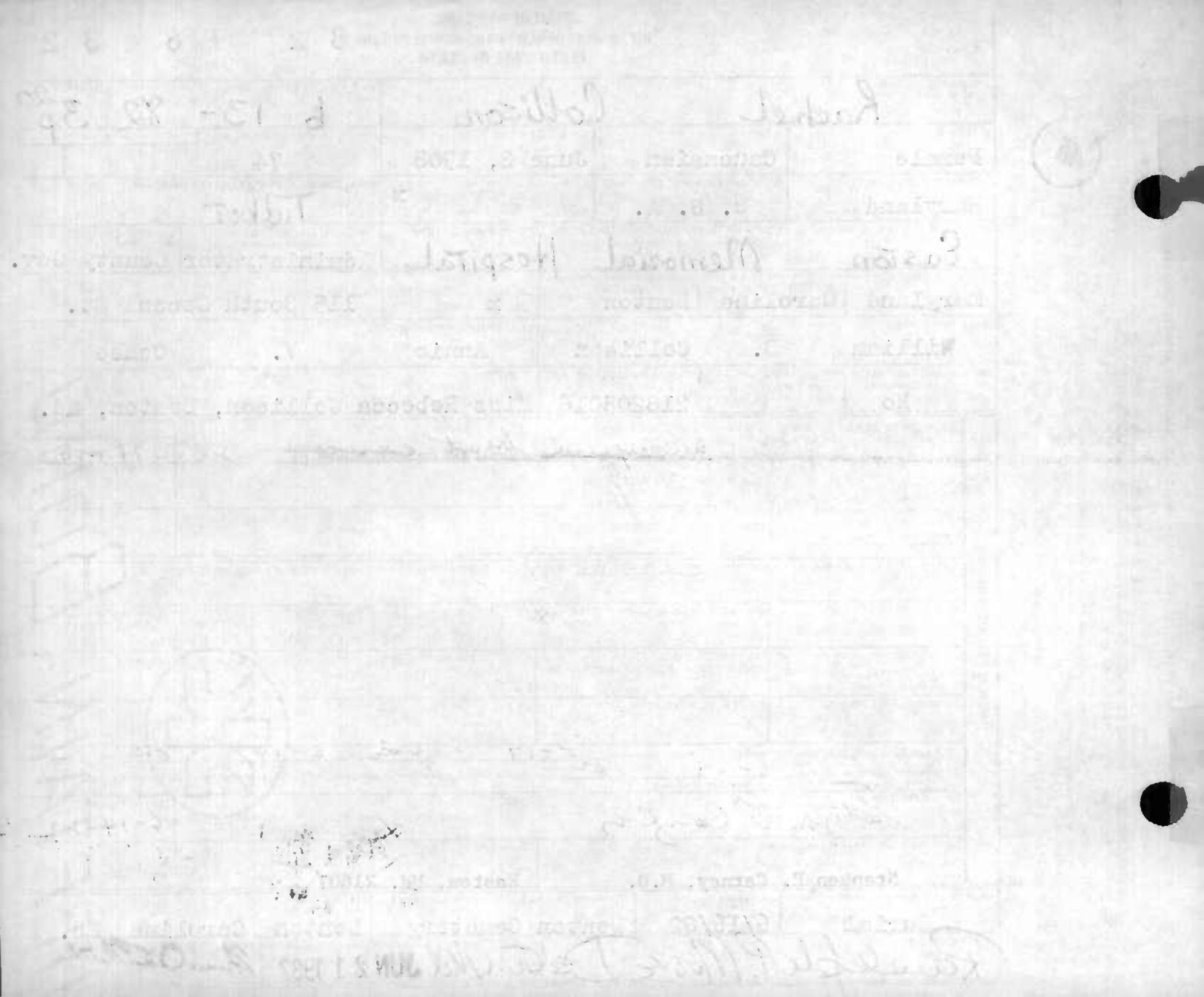
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered to us as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 6 4 8 2	
										REG. NO.	
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 20	
		<i>Rachel</i>			<i>Collison</i>		<i>6-13-82</i>			30 M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 1 HR	
Female		Caucasian		June 2, 1908			74 YRS			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH	
Maryland		U. S. A.					<i>Talbot</i>			<i>Easton</i>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		Caroline		Denton		Administrator			County Gov.		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		William	B.	Collison	Annie			V. Cohee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		218205016		Miss Rebecca Collison, Denton, Md.						18 mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Widepread breast cancer</i>											
DUE TO, OR AS A CONSEQUENCE OF { (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>5-17</i> , 19 <i>82</i> , to <i>6-14</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>6-14</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>6-14-82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Stephen P. Carney, M.D.		Easton, Md. 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE	
Burial		6/16/82		Denton Cemetery			Denton			Caroline	Md.
24. FUNERAL DIRECTOR NAME		ADDRESS		24a. DATE REC'D. BY REGISTRAR			24b. REGISTRATION NO.				
Randolph P. Moore		Denton, Md.		JUN 21 1982			Theresa O'Callahan				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Please be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 6 4 8 3		
										REG. NO.		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
(TYPE OR PRINT)			6 - 17 - 82							5:50 PM		
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST					
Nannie E Dennis												
3. SEX female			4. RACE B.I.K.		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY VA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		70			Talbot		
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) Memorial Hospital Domestic							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE Md.			13b. COUNTY Q.A.		13c. CITY OR TOWN Grasonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS R#1 Box 413		
14. FATHER'S NAME Dorsey			FIRST		LAST		15. MOTHER'S MAIDEN NAME Beatrice			LAST fitchett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-13-							17. INFORMANT frank Dennis		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D } DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours Years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Respiratory Failure @ ⑥ Hypertension												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/17/82</u> to <u>6/17/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.												
22b. SIGNATURE Dr. Gregg Rhodes MD												
22c. ATTENDING PHYSICIAN			22d. DEGREE			22e. ADDRESS			22f. DATE SIGNED 4/18/82			
<i>Dr. Gregg Rhodes</i>						400 Dutchmen Ln., Easton Md.			2169			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 6-21-82			23c. NAME OF CEMETERY OR CREMATORIAL Robinson			23d. LOCATION CITY OR TOWN Grasonville Q.A. Md.			
24. FUNERAL DIRECTOR NAME George H. Dashiell			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JUN 24 1982			25b. REGISTRAR'S SIGNATURE <i>Jan Martin</i>			

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814 X 98 V 44 different A.31 .6M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 6 4 8 4			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR			
ERNEST					DICKERSON	6-13-82						9 ⁴⁹ AM			
3. SEX MALE			4 RACE BLACK	5. DATE OF BIRTH OCT 1, 1900			6. AGE 81			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
BIRTHPLACE COUNTRY MARYLAND			7b CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT			MD.			
10. CITY OR TOWN OF DEATH EASTON, MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION RETIRED			12b. KIND OF BUSINESS OR INDUSTRY FARMING						
13a. STATE MARYLAND			13b. COUNTY CAROLINE			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS GENERAL DELIVERY						
14. FATHER'S NAME WILLIAM			15. MOTHER'S MAIDEN NAME VICTORIA (MNM) JOHNSON												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NO 212-16-7668			17. INFORMANT RCRDS OF MEMORIAL HOSPITAL			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1990			ABDOMINAL & HEPATIC CAR-						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b)			CINOTMATOSIS			7-10 MO-						
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC U.I.T. I.															
19a. DATE OF OPERATION 8-3-81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death												22b. DATE SIGNED 4/4/1982			
27a. SIGNATURE <i>John Knud-Hansen</i>			27b. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
27c. PHYSICIAN'S NAME (TYPE OR PRINT) John Knud-Hansen, M.D.			22e. ADDRESS Easton, Md. 21601												
23a. BURIAL, CREMATION, REMOVAL SPECIES BURIAL			23b. DATE 6-17-1982			23c. NAME OF CEMETERY OR CREMATORIUM ST PAUL CEMETERY			23d. LOCATION CITY OR TOWN WILLISTON, CAROLINE			COUNTY MD			
24. FUNERAL DIRECTOR NAME Hill Funeral Home			ADDRESS Denton, Md. 21629			25a. DATE REC'D. BY REGISTRAR JUN 21 1982			25b. REGISTRAR'S SIGNATURE <i>James O. Miller</i>						

PVS 5-19-69

00238510

Trans 3

I ORDERED THIS

RECEIVED

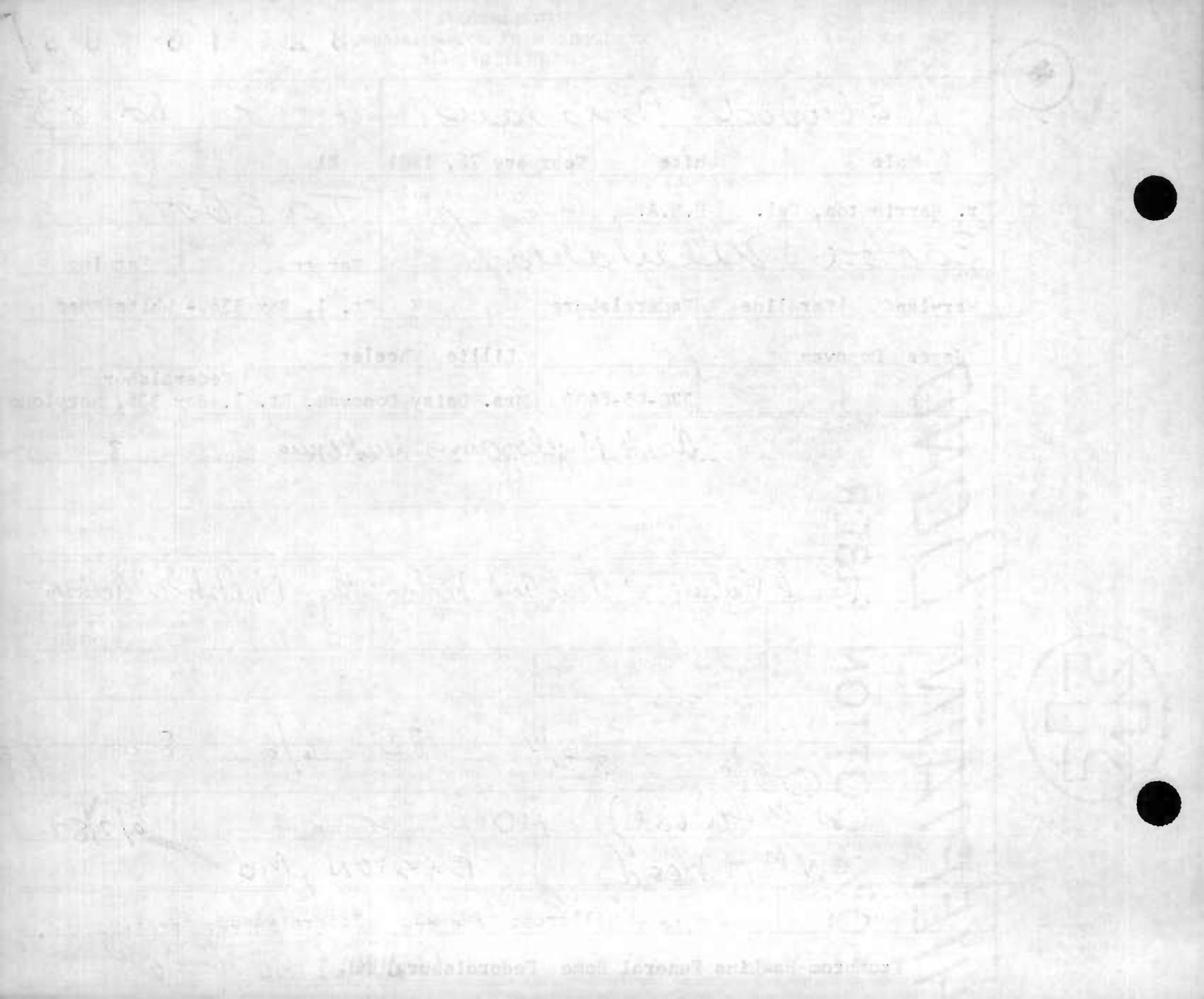
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 . 1 6 4 8 5	
												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			<i>Elwood Donovan</i>						<i>6 - 9 82</i>			<i>8:00 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
Male			White			February 28, 1901			81			IF OVER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>			MD.	
8. CITY OR TOWN OF DEATH <i>Easton Maryland</i>			NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
10. USUAL RESIDENCE IF NOT IN HOSPITAL OR OTHER INSTITUTION (GIVE RESIDENCE BEFORE ADMISSION) 11a. STATE <i>Maryland</i>			11b. COUNTY <i>Caroline</i>			13c. CITY OR TOWN <i>Federalsburg</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>Rt. 1, Box 336, White Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Donovan</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie Wheeler</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myelogenous Leukemia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3</i>				
2050			220-05-8406										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)										
			(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Renal Failure 2° Uric Acid Nephropathy. Metabolic Acidosis</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>82</i>			CITY OR TOWN <i>82</i>			COUNTY STATE <i>82</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/6</i> to <i>8/2</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Wm H Wood</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>6/7/82</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm H Wood</i>			22e. ADDRESS <i>EASTON, Md</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>June 9, 1982</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Federalsburg, Caroline</i>			COUNTY STATE <i>Md</i>	
24. FUNERAL DIRECTOR NAME <i>Frampton-Hawkins Funeral Home</i>			ADDRESS <i>Federalsburg</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 11 1982</i>			25b. REGISTRAR'S SIGNATURE <i>James J. Hawkins</i>				
BP _____													
DHMH - 16 50M 1/81 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # may be _____

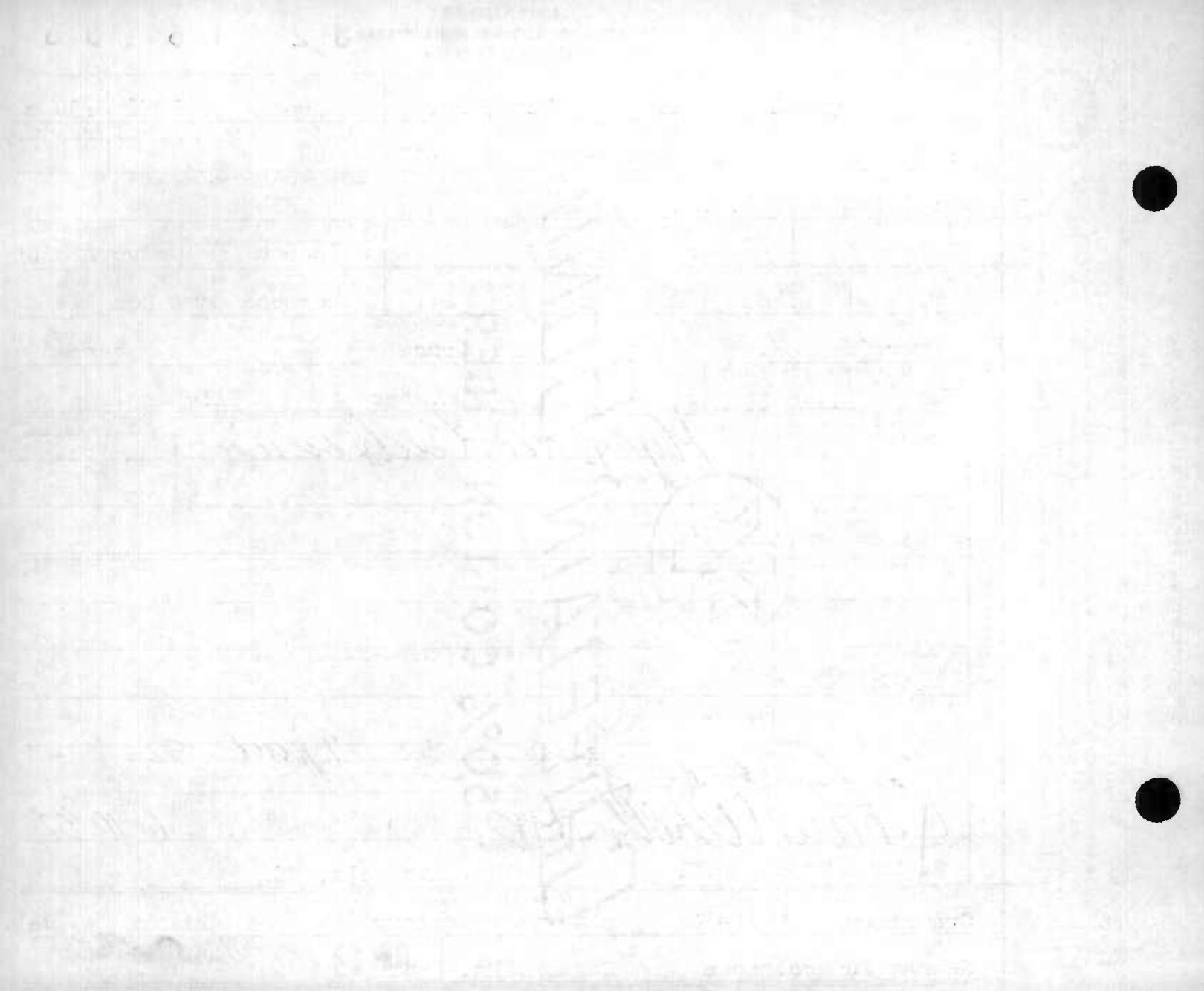
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 , 1 6 4 8 6		
												REG. NO.		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Francis X. Ferg, Jr.						June 9 1982			8:30 p.m.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS		
Male			Caucasian			SEPT 4 1901			80			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
Pennsylvania			U.S.A.						Talbot			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Tilghman			Dogwood Cove Road			salesman			advertising					
13a. STATE Md.			13b. COUNTY Talbot			13c. CITY OR TOWN Tilghman			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Dogwood Cove Road		
14. FATHER'S NAME FIRST Francis			MIDDLE X.			LAST Ferg			15. MOTHER'S MAIDEN NAME FIRST Grace			LAST Vernon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes			1920-1922			165-05-9726 Iola A. Ferg			Tilghman, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			2059			Myogenic Leukemia								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF								
(c)						DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) this hospital attended the deceased from _____, 19____, to _____, 19____, that (II) we last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) certify that the body later died.														
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ADDRESS			St. Michaels, Md.			16-10-82		
R. Lane Wroth, M.D.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6-10-82			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes			COUNTY Sussex		STATE Del.
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JUN 14 1982			25b. REC'D. BY CLERK Anne S.					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16487							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2d HOUR					
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	<input checked="" type="checkbox"/>			6	20	1982	748 M					
female	BK	7/30/09	72 yrs.			<input type="checkbox"/>			DATE PRONOUNCED DEAD			6-20	1982	748 M			
BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
EASTON			MEMORIAL HOSPITAL														
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Md. Baltimore			Baltimore			<input type="checkbox"/>			467 mouse CT.								
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> ND.			17. INFORMANT			APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH			
Sampson				Johnson	Ethel			Randolph Johnson			Cephas						
18. CAUSE OF DEATH (Enter only one cause per line for Part 1a, and up to PART 1 DEATH WAS CAUSED BY			19. SOCIAL SECURITY NO.			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. TIME OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
IMMEDIATE CAUSE (a)									21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c PART 1 OR PART 2)		
4149 Conditional if, any, which gave rise to immediate cause (a) stating the under- lying cause last.									21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21h. LOCATION STREET CITY OR TOWN COUNTY STATE		
(b)																	
(c)																	
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. TITLE (SPECIFY) M.D.			22c. MEDICAL EXAMINER											
ACTUAL SIGNATURE															DATE SIGNED 6-20-82		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			23e. COUNT					
Burial			6-26-82			ST. Paul			Denton Caroline			md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
George H. Dashiell			Easton, md.			JUN 24 1982			James Jean Arthur								

exfoliates and crusts

strains - 200

symmetric rash
2nd day starts
no edema - 1910 AM

second visit
11:30 AM - 8-6-81 living
conditions better in general

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 6488

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 3B. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS 401 W. PINESTON STREET, BALTIMORE, MARYLAND 21201. PAPERS TO BURIAL, CREMATION, OR REMOVAL.

DISCUSSION OF THE MUSEUMS IN THE STATE OF MICHIGAN

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	RECEIVED	
Leon H. Gibson							REC'D	
2. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2a. DATE KNOWN OF ESTI- MATED	MONTH DAY YEAR	
male	BLK.	4 18 31 51		MONTHS DAYS	HOURS MIN	R 6 18 1982	6 PM	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.		U.S.A.				Talbot		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE)		
Trappe		RT #2 Box 42						
13a. STATE 13b. COUNTY								
13c. CITY OR TOWN								
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>								
13e. STREET ADDRESS RT. #2 Box 42								
14. FATHER'S NAME FIRST MIDDLE LAST								
William Camper Rosie Gibson								
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Rosie Williams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) NO								
16b. SOCIAL SECURITY NO.								
17. INFORMANT Anna								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3314 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Actual Signature: R. Paul Abbott, M.D., Medical Examiner Examiner's Name (Type or Print): R. Paul Abbott, M.D., Medical Examiner Address:								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)								
Burial		23b. DATE 6/23/82		23c. NAME OF CEMETERY OR CREMATORIAL Paradise		23d. LOCATION CITY OR TOWN Trappe Talbot Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 111N 24 1082		25b. REGISTRAR'S SIGNATURE Thomas Van Harten		
George H. Dashiel		Easton, Md.						

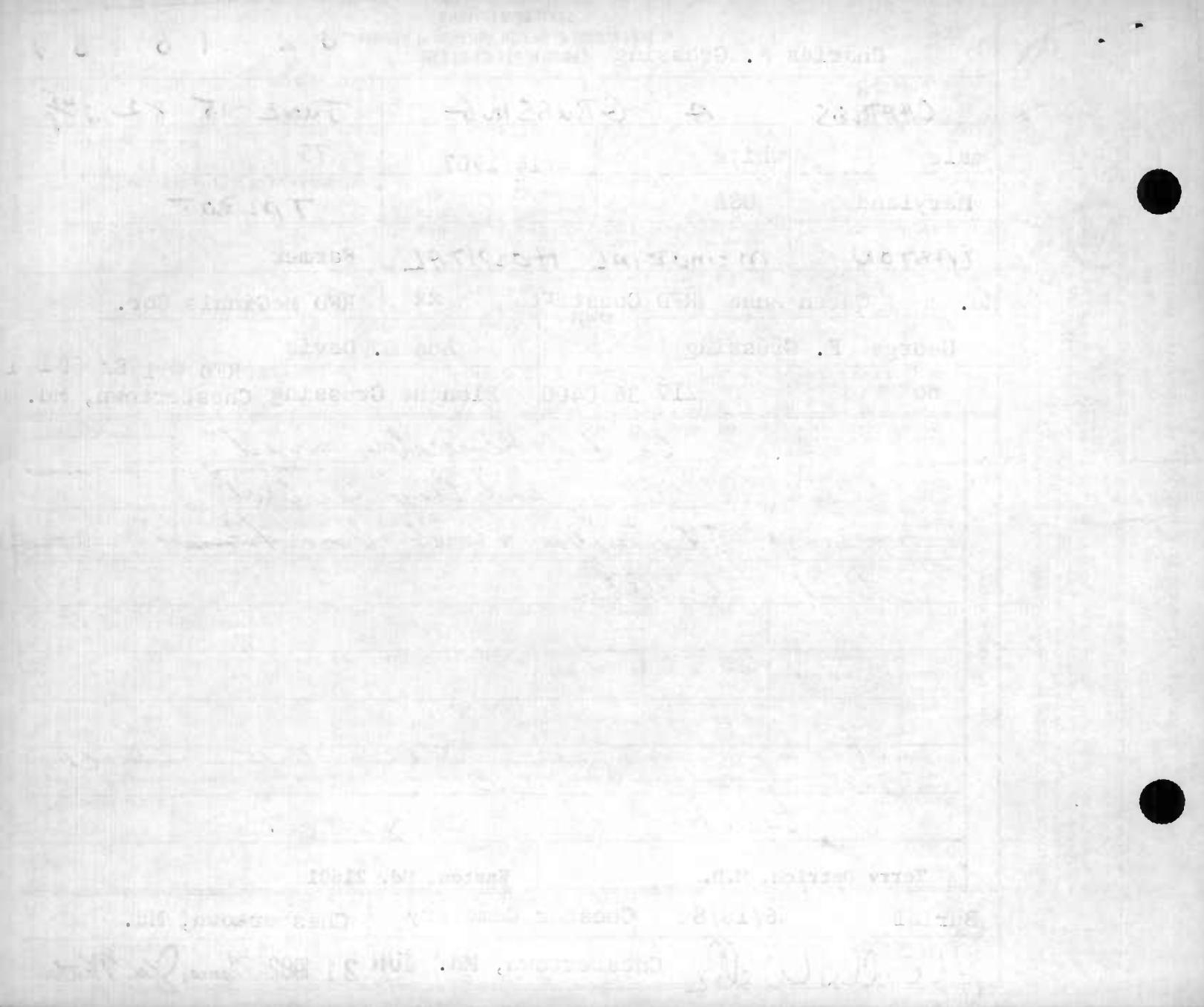
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. If it is not done so, the physician should be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate returned by the physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE Charles A. Grussing CERTIFICATE OF DEATH										8 2 1 6 4 8 9				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>CHARLES</i>			<i>A</i>	<i>GRUSSING</i>		<i>June 15 82</i>			<i>8</i>	<i>15</i>	<i>1982</i>	<i>2 45 p.m.</i>		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
male			white		MONTH <i>4</i> DAY <i>14</i> YEAR <i>1907</i>			75			MONTHS <i>0</i> DAYS <i>0</i>			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 4 HRS		
Maryland			USA						TALBOT			YRS. <i>MD.</i>		
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
EASTON			MEMORIAL HOSPITAL			Farmer								
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md.			Queen Anne			RFD Chester town			RFD McGinnis Cor.					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
George F. Grussing						Ada E. Davis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO. (YES, NO, UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
no			217 36 0400			Blanche Grussing			RFD # 1 Bx 601-1 Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>3319</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										<i>Cardio Respiratory arrest</i>				
(b) <i>Severe end Stage cerebral</i>														
(c) <i>Degeneration + cerebro Vasc. Disease</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>atrial Fibrillation</i>														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12</i> - <i>19 82</i> , to <i>6-15</i> <i>19 82</i> , that (I) (we) lost soul the deceased alive on <i>6-15 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.														
22b. SIGNATURE <i>Metrich N.</i>						DEGREE						22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Terry Detrich, M.D.			Easton, Md. 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6/18/82			23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY	STATE	
Burial														
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
<i>Willie Well</i>												<i>Frances Jean Kather</i>		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16490

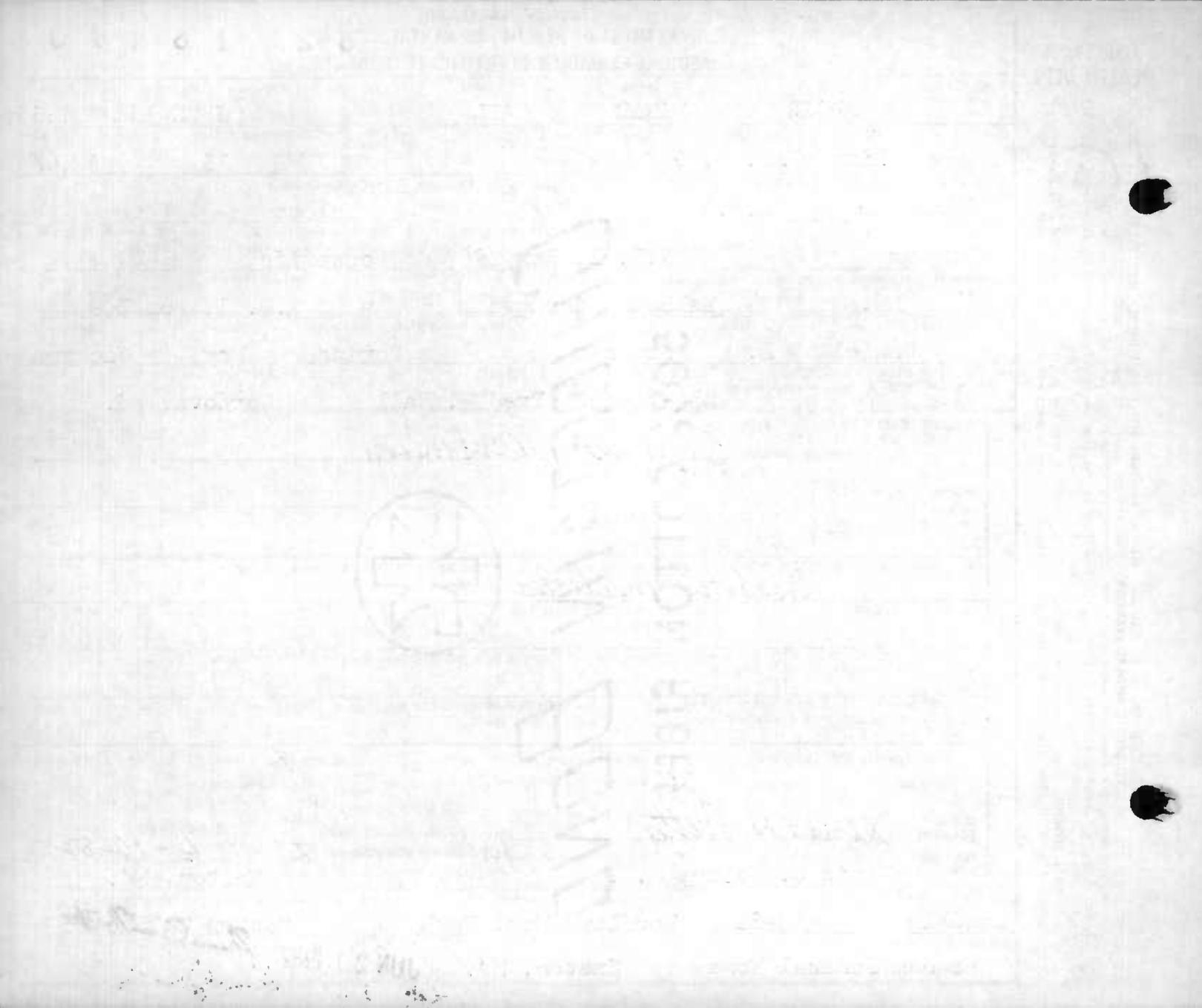
FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First ADDIE	Middle MARIE	Last HALL	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> JUNE 15 1982	2b. HOUR 7:15 p.m.
3. SEX Female	4. RACE White	S. DATE OF BIRTH JAN. 8, 1908	6. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot	
10. CITY OR TOWN OF DEATH Cordova		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. 1, Box 299			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Talbot	13c. CITY OR TOWN Cordova	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D. 1, Box 299	
14. FATHER'S NAME First Daniel L.		Middle Seymour	Last 	15. MOTHER'S MAIDEN NAME First Rowena	Middle May	Last Jackson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-74-8934		17. INFORMANT Fred M. Hall	ADDRESS Cordova, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) Diabetes mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Louis S. Welty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>6-16-82</i>		
EXAMINER'S NAME (Type) Louis S. Welty, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-18-82	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Mem. Park	23d. LOCATION (City or Town) Easton		(County) Easton (State) Delaware
24. FUNERAL DIRECTOR Newnam Funeral Home		ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR JUN 21 1982	25b. SIGNATURE <i>[Signature]</i>	



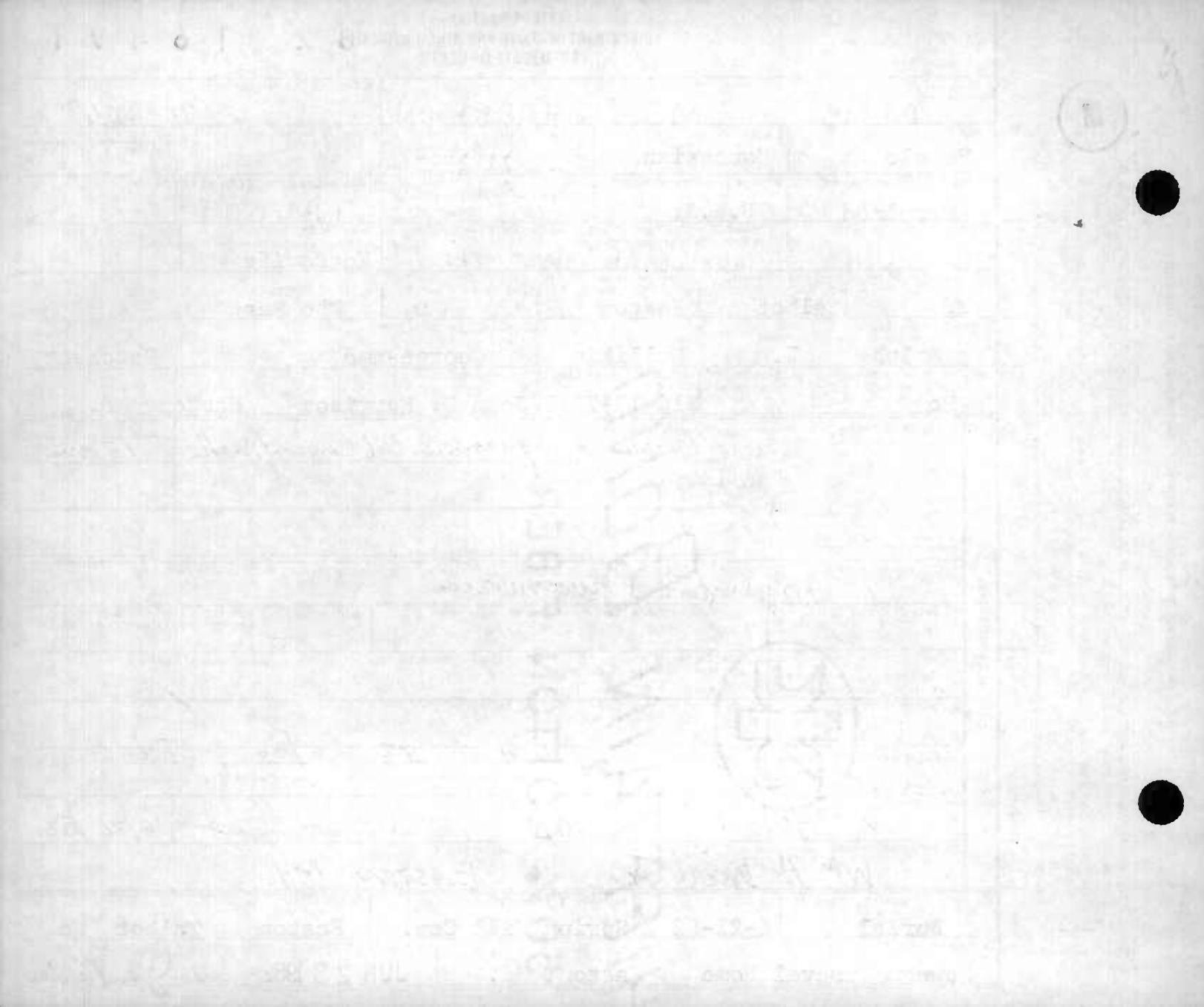
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	4	9	1
												REG. NO. 62082625 AM						
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
DORIS M. HARRISON									6 20 82			6 25 AM						
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			SEPT 11 1923			58 YRS.									
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.															
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md.			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS The Rest						
14. FATHER'S NAME FIRST MIDDLE LAST Ralph F. Mullikin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgeanna Patchett															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-16-7177			17. INFORMANT John T. Harrison			ADDRESS Easton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1950 Metastatic Squamous Cell Cancer of Neck APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos.																		
DUE TO, OR AS A CONSEQUENCE OF { (b) }																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration Pneumonia																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 6/11/82 to 6/20/82, that (I) (we) last saw the deceased alive on 6/19/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Wm H Wood Jr.			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 6/20/82									
22e. ADDRESS EASTON MD.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-22-82			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cem.			23d. LOCATION CITY OR TOWN Easton COUNTY Talbot STATE Md.									
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JUN 23 1982			25b. REGISTRAR'S SIGNATURE James J. Newnam									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be palled and called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 6 4 9 2 CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR
<i>Earle</i>				<i>Calloway</i>	<i>Harrison</i>	<i>6-17-1982</i>					26 HOUR
1. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Male			Cau			MONTH DAY YEAR			IF UNDER 1 YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA			Nov 16, 1909			Talbot		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hospital at Easton			12a. Aircraft wkr (Ret)					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Talbot			Claiborne			13e. STREET ADDRESS		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST
Lewis Harrison						Essie Self					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			212-07-7266			Florence A. Harrison, Claiborne, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal and hepatic failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
5770 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute pancreatitis</i> (c) <i>Gulcs</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/30/82</i> , 19 <i> </i> , to <i>6/17/82</i> , 19 <i> </i> , that (I) (we) last saw the deceased alive on <i> </i> , 19 <i> </i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stanley Bysshe, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/17/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Stanley Bysshe, M.D.			Easton, Md. 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Burial			Jun 19, 1982			St. Paul's Luth.			Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. SIGNATURE		
<i>Harmon E. Leonard, St. Michael, Inc.</i>						JUN 24 1982			<i>Harmon E. Leonard, St. Michael, Inc.</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	4	9	3	
												REG. NO. 16493							
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Hilda			H. AUSE			Harrison			6 18 82						4 55 P.M.	
2. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)										
FEMALE			WHITE			MONTH JUNE DAY 7, YEAR 1915			67										
7. BIRTHPLACE			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH										
MARYLAND			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			TALBOT										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
EASTON			Memorial Hospital			HOUSEWIFE			HOME										
13a. STATE			13b. COUNTY			14. INSIDE CITY LIMITS?			13c. STREET ADDRESS										
MARYLAND			TALBOT			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			105 W. MARENGO ST.										
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																
FIRST WALTON A. HAUSE			FIRST MIDDLE LAST HATTIE G. KRAFT																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			105 W. MARENGO							
NO			220-26-2961			EDWARD N. HARRISON			ST. MICHAELS,			MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the breast</i> 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) this hospital attended the deceased from 5-6 1982 to 6-18 1982, that (I) (we) last saw the deceased alive on 6-15 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>Stephen P. Carney</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-18-82										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN P. CARNEY			22e. ADDRESS EASTON, MARYLAND 21601																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL XXXX			23b. DATE JUNE 21, 1982			23c. NAME OF CEMETERY OR CREMATORIAL OLIVET CEMETERY			23d. LOCATION ST. MICHAELS TALBOT MD.										
24. FUNERAL DIRECTOR NAME <i>Harrison Ed Leonard, St. Michaels</i>			25a. DATE REC'D. BY REGISTRAR JUN 24 1982			25b. REGISTRAR'S SIGNATURE <i>None Jan 1982</i>													
BP _____																			
DHMH-16 50M 1/81 (VRA 15, 4)																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR			ITEM 13a-e Phone no 7-12-82			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 2 6 4 9 4					
									REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			21b. HOUR					
Cindy			Hill			6 29 82			1:00P.M.					
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH 6 DAY 20 YEAR 79			6. AGE (IN YEARS LAST BIRTHDAY) 104-100 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unknown			7b. CITIZEN OF WHAT COUNTRY? unknown			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD					
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown			12b. KIND OF BUSINESS OR INDUSTRY unknown					
13a. STATE MD. unknown			13b. COUNTY TALBOT			13c. CITY OR TOWN BOSTON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS unknown HOUSE IN THE PINES		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.			16b. SOCIAL SECURITY NO. 217-58-4970			17. INFORMANT			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DO NOT WRITE IN THIS COLUMN			Sepsis Pancreas R leg ABVD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from 6/29/82 to 6/29/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.														
27a. SIGNATURE R. Lunes M			27b. DEGREE			27c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			27d. DATE SIGNED 6/29/82					
28a. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 6/29/82			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board			25a. DATE REC'D. BY REGISTRAR 2 1982			25b. REGISTRATION NUMBER 1111 2 1982								
DHMH-16 30M 2/80 (VRA 15, 4)														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner shall notify the coroner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 4 9 5	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Alice M Hutchins						6-30-82						3:10A M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		BKI		MONTH	DAY	YEAR	73			MONTHS	DAYS	HOURS	MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD			
Md		USA		Memorial			Talbot			Domestic			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
EASTON		Memorial										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md		Talbot		Cordova		YES <input type="checkbox"/>			Rancho, Box 120 A				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS		
John		W		Wilmer	Hettie			4100			Stewart		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		4100		francis			Acute myocardial infarction			< 24 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Arteriosclerotic heart disease			Uncertain								
DUE TO, OR AS A CONSEQUENCE OF													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Metastatic breast carcinoma													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from (a-1) 1980 to (a-30) 1982, that (we) lost saw the deceased alive on (a-29) 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.													
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Robert W. Trever, M.D.											6-30-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			RD 3 Easton Md. 21601					
Robert W. Trever, M.D.													
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial		7/31/82		Newtown			Cordova			Talbot		Md	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
George & Debra E. Tressel					JUL 7 1982			Chesapeake Pathology					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 4 9 6					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR					
RILEY Y. JOHNSON						June 9 1982						3:50 P.M.					
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			BK	MONTH	DAY	YEAR	64			MONTHS	DAYS	HOURS	MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			TALBOT MD.					
N.C.			USA														
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
EASTON			MEMORIAL HOSPITAL			Laborer											
13a STATE			13b COUNTY	13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS								
MD			Talbot	St Michaels		YES <input type="checkbox"/> NO <input type="checkbox"/>			Box 285								
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS							
John			H	Johnson	Anne			Bullups									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
XES			WWII						4280			CARDIOPULMONARY ARREST					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE														
			(c) CONGESTIVE HEART FAILURE														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PROGRESSIVE RENAL INSUFFICIENCY																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from 6/4 1982 to 6/9 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We did / did not) view the body after death.																	
22b. SIGNATURE W.Bremer			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/9/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BREMER			22e. ADDRESS 103 E. CHESTNUT ST ST. MICHAELS MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/15/82 Oak Grove			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN Elizabethtown			COUNTY NC					
24. FUNERAL DIRECTOR NAME Lynn H. Bremer									25a. DATE REC'D. BY REGISTRAR JUN 18 1982			REGISTRAR'S SIGNATURE Diane J. Muller					

CHILOE ISLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8216497				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	June 2 1982							6:30 A.M.	
Otto H. Kaufman														
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			Caucasian			Aug. 29, 1895			86 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.		
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farm					
13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 201 Federal Street		
14. FATHER'S NAME FIRST August			MIDDLE Kaufman			15. MOTHER'S MAIDEN NAME FIRST Wilhelmina			MIDDLE (not known)			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217307680			17. INFORMANT Mrs. Margaret Palmer, Denton, Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			4100			HCHD with Acute Myocardial Infarction			19. DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									20. DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1980			21f. LOCATION STREET EASTON			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 27 1982 , to 6/2 1982 , that (I) (we) last saw the deceased alive on May 27 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE Wm H Wood Jr MD			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS EASTON MD			22f. DATE SIGNED 6/2/82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/4/82			23c. NAME OF CEMETERY OR CREMATORIAL Ridgely Cemetery			23d. LOCATION CITY OR TOWN Ridgely			23e. COUNTY Caroline		
24. FUNERAL DIRECTOR NAME DANOLPH P. MOORE			ADDRESS DENTON, MD.			25a. DATE REC'D. BY REGISTRAR JUN 8 1982			25b. REGISTRAR'S SIGNATURE James J.					
DHMH-16 30M 2/80 (VRA 15, 4)														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8	2	1	6	4	9	8		
					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST		2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Robert	C.	Kirk		6/2/82					12 ³⁰ PM				
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR				
M	W	MAR 13 1932		50	YRS.	MONTHS	DAYS	HOURS	IF UNDER 24 HRS.				
7c. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
MD	USA				TALBOT								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY							
Easton	Allemarsh				CONDUCTOR	RAILWAY							
13. RESIDENCE IF INHABITED 14. STATE	14. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14e. STREET ADDRESS	RT 3, Box 100									
MD	CAROLYNET DENTON												
14. FATHER'S NAME	MIDDLE	15. MOTHER'S MAIDEN NAME											
ALBERT	F.	THELMA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS										
YES	KOREAN WAR 214284970	ALBERTA KIRK DENON MD											
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:	IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4100	Carotid artery												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Myocardial abscess												
	(c) Myocardial infection												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
21a. DATE OF OPERATION	21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				21c. AUTOPSY?	21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)	21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART I OR PART II)											
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21j. LOCATION STREET	LIN. OR TOWN	COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from now the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) know the body after death.	22b. SIGNATURE <i>Alexander J. Schmidt</i>	22c. DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. L. H. Schmidt MD	22e. ADDRESS Easton, MD	22f. DATE SIGNED 20 June 82							
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL	23b. DATE 6/7/82	23c. NAME OF CEMETERY OR CREMATORIAL MEADOW RIDGE	23d. LOCATION DORSEY A.A. MD.										
24. FUNERAL DIRECTOR NAME Moore Funeral Home Denton, Md	25a. DATE REC'D. BY REGISTRAR JUN 8 1982	25b. REGISTRAR'S SIGNATURE James Gardner											

KOREAN WORDS

234

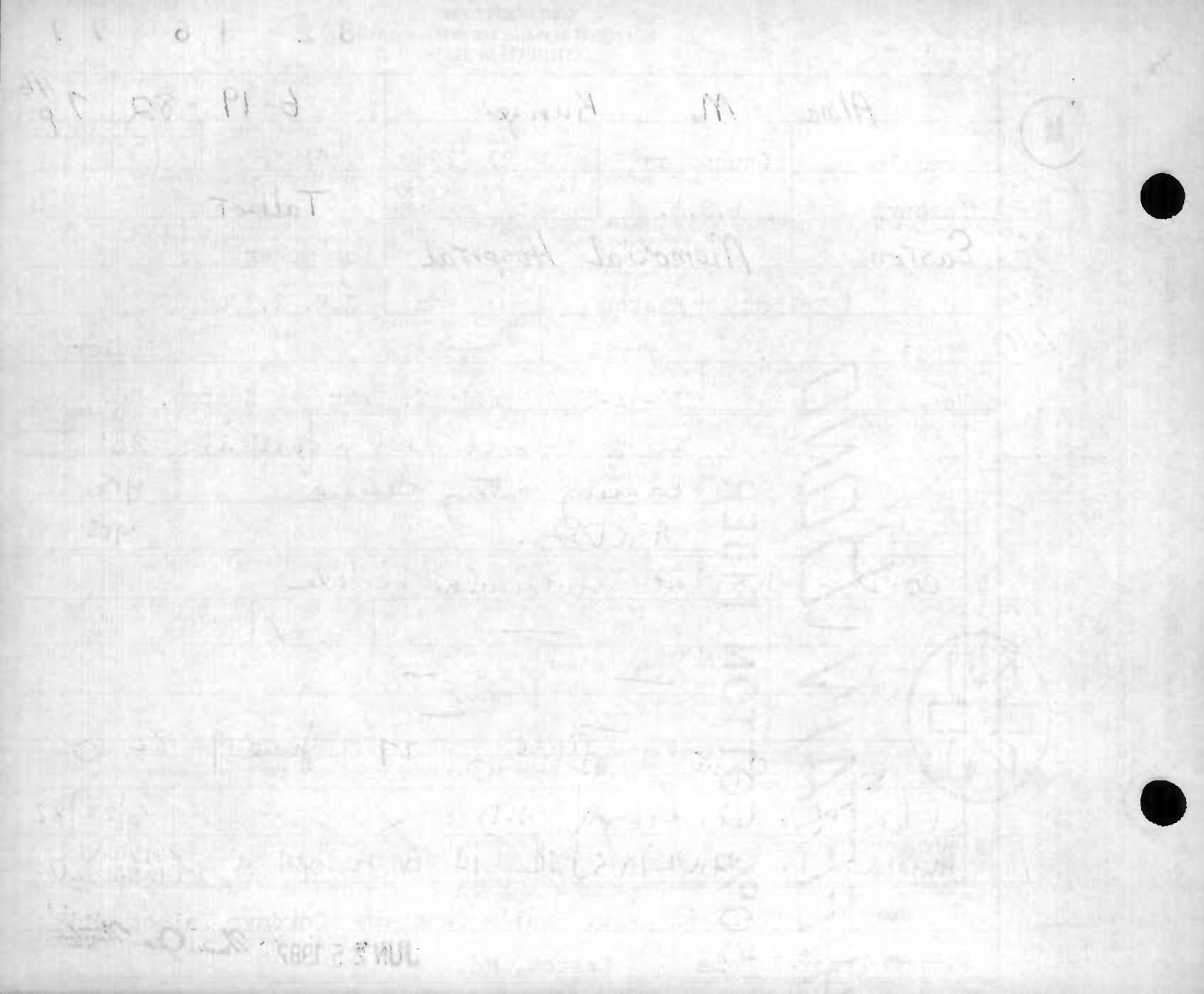
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be mailed or faxed to him/her.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 4 9 9	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Alma M. Kunze						6-19-82			1982	19	1982	1 p.m.	
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Female			Caucasian			MONTH AUG DAY 27 YEAR 1900			81 YRS			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Missouri			U.S.A.						Talbot				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton			Memorial Hospital			Homemaker							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Md.			Talbot			Easton						R.D. 2, Box 245	
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST	
Emil			F.			Kunze			Martha			Fiedler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			214-42-8167			Emily T. Henry			Easton, Md.			30'	
18. CAUSE OF DEATH (Enter only one cause per line for tallies, and etc.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 30' 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary artery disease yrs. (c) ASCVD yrs.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a COPD - hx left ventricular failure													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
—			—			—			—			—	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			—			—	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —			—			—	
22a. I certify that (i) this hospital attended the deceased from April 19, 1982, to June 19, 1982, that (ii) we last saw the deceased alive on April 19, 1982, and that in (iii) our opinion death occurred on the date and hour and from the causes stated above. (If deceased did not die in the hospital, check here.)													
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED				
Albert Paulson MD			MD						6/22/82				
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS			22h. CITY OR TOWN			22i. COUNTY			22j. STATE	
Albert T. DAWKINS Jr.			14 W. Aurora St			Easton			Maryland			MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	
Burial			6-22-82			St. Paul's Cemetery			Cordova Talbot			Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Newnam Funeral Home			Easton, Md.			JUN 25 1982			Anne Quigley				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEA
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR OWN USE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 10 DAYS)
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	16500									
1- FOR STATE REGISTRAR			LAST									2a. DATE KNOWN TO OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<i>Alice K. Little</i>		6	28	1982	9:00 AM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		MONTH	DAY	YEAR	2b. HOUR			
<i>Female</i>			<i>White</i>			<i>3 2 47</i>			<i>35 yrs.</i>							<i>6</i>	<i>28</i>	<i>1982</i>	<i>9:00 AM</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED		X NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		
<i>Md</i>			<i>USA</i>									<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<i>Talbot</i>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, QR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>EASTON</i>			<i>Memorial</i>									<i>Domestic</i>										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
<i>Md</i>			<i>Car</i>			<i>Ridgely</i>						<i>Reutel #1 Box 49-L</i>										
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for item 18, part 1.) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<i>Carroll</i>			<i>Hogson</i>									<i>James Little</i>										
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			18b. SOCIAL SECURITY NO.			18c. INFORMANT			18d. ADDRESS													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>R. Lane Wroth</i>			22b. DATE REC'D. BY REGISTRAR M.D.			22c. TITLE (SPECIFY) M.D.			22d. MEDICAL EXAMINER			DATE SIGNED <i>6-29-82</i>										
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS									St. Michaels, Md. 21663										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL old chapel			23d. LOCATION CITY OR TOWN			COUNTY			STATE							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR George Dashiel			25b. REGISTRAR'S SIGNATURE Yan Miller													
George Dashiel						Easton, Md. 21601			7-19-82													

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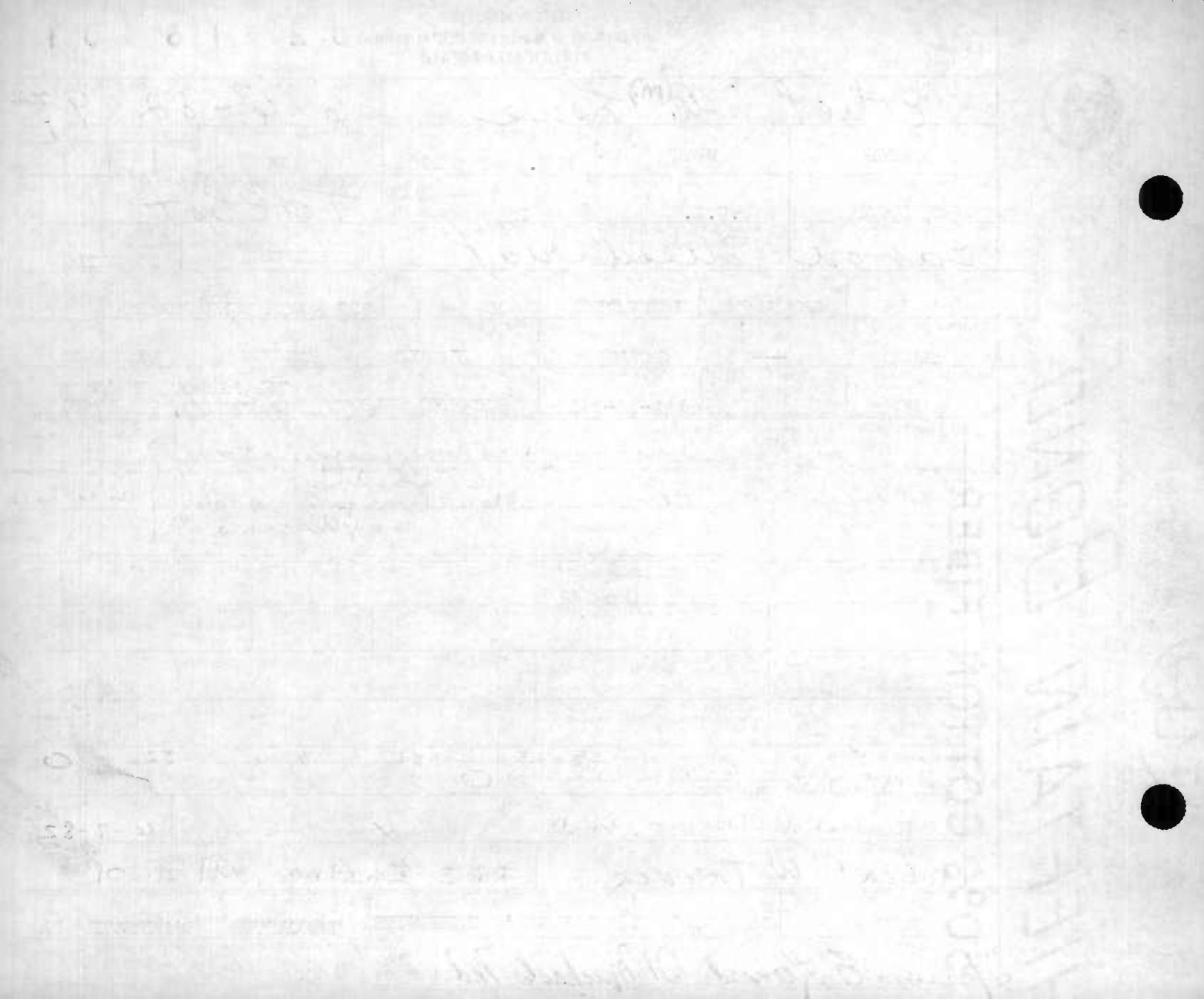
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	5	0	1
												REG. NO. 8216501						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	16 HOUR						
<i>Ethel M. Howe</i>						<i>6-6-82</i>			<i>JUN</i>	<i>6</i>	<i>1982</i>	<i>9 PM</i>						
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	16. AGE (IN YEARS LAST BIRTHDAY)						
FEMALE			WHITE			<i>FEB. 8 1906</i>			<i>FEB.</i>	<i>8</i>	<i>1906</i>	76 YRS.						
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			MARRIED	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	DIVORCED	<input checked="" type="checkbox"/>				
PENNSYLVANIA			U.S.A.															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
<i>Easton, Maryland</i>						<i>HOUSEWIFE</i>			<i>DOMESTIC</i>									
13a. STATE PA			13c. CITY OR TOWN LANCASTER			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 829 NORTH DUKE STREET									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
ELMER --- GRAVER			JENNIE COWDEN DIETRICH															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS 701 ASHBOURNE AVENUE LANCASTER, PA 17601									
NO			182-34-3430			GWENDOLYN TALBOTT												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute and chronic respiratory</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive pulmonary</i>												<i>failure</i>						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>emphysema</i>												<i>Uncertain</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												<i>None</i>						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) this hospital attended the deceased from <i>5-25</i> , 19 <i>87</i> , to <i>6-6</i> , 19 <i>82</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>6-6</i> , 19 <i>82</i> , and that in my (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated <i>above</i> . <input checked="" type="checkbox"/> We did not view the body after death.																		
22b. SIGNATURE <i>Robert W. Trevor, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6-7-82</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert W. Trevor</i>			22e. ADDRESS <i>RD 3 Easton, Md. 21601</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 9, 1982			23c. NAME OF CEMETERY OR CREMATORY MELLINGER'S MENNONITE			23d. LOCATION CITY OR TOWN LANCASTER			COUNTY LANCASTER	STATE PA					
24. FUNERAL DIRECTOR NAME <i>Harrison E. Leonard, St. Michaels, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 10 1982</i>			25b. REGISTRAR'S SIGNATURE <i>Janice Janice</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82	16502	
										REG. NO.		
1. FOR STATE REGISTRAR	2. DATE OF DEATH MONTH DAY YEAR										2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	McCLYMENT				6 - 20 - 82	1 PM	
Henrietta U. McCLYMENT												
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			
Female			White			September 15, 1899			82 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			USA						TALBOT			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton			William Hill Manor			Wife			Home			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS
Maryland			Anne Arundel			Odenton						508 Rita Drive
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT Son ADDRESS 508 Rita Drive Capt. Henry C. McClyment, Jr., Odenton, Md.
Louis Aquilla Usilton			Mary Deborah Holliday			No			219-14-1462			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE BETWEEN ONSET AND DEATH 3-4 days		
3429 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) <input checked="" type="checkbox"/> hemiparesis + COPD		
{ DUE TO, OR AS A CONSEQUENCE OF (c)										years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ASCVD. & CAD + hypertension - interstitial fibrosis -												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/12 1982 to 6/20 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. SIGNATURE Albert T. Dankins Jr., M.D.						DEGREE			22c. DATE SIGNED 6/21/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
Albert T. Dankins Jr., M.D.			4 N. AU KONT ST EASTON MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
Burial			June 23, 1982			Chesterfield			Centreville, Queen Co. Md.			
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. JURISDICTION BY REGISTRAR						
Barton Bros.						JUN 29 1982						
James H. Barton, Jr., Centreville, Md. 21617												

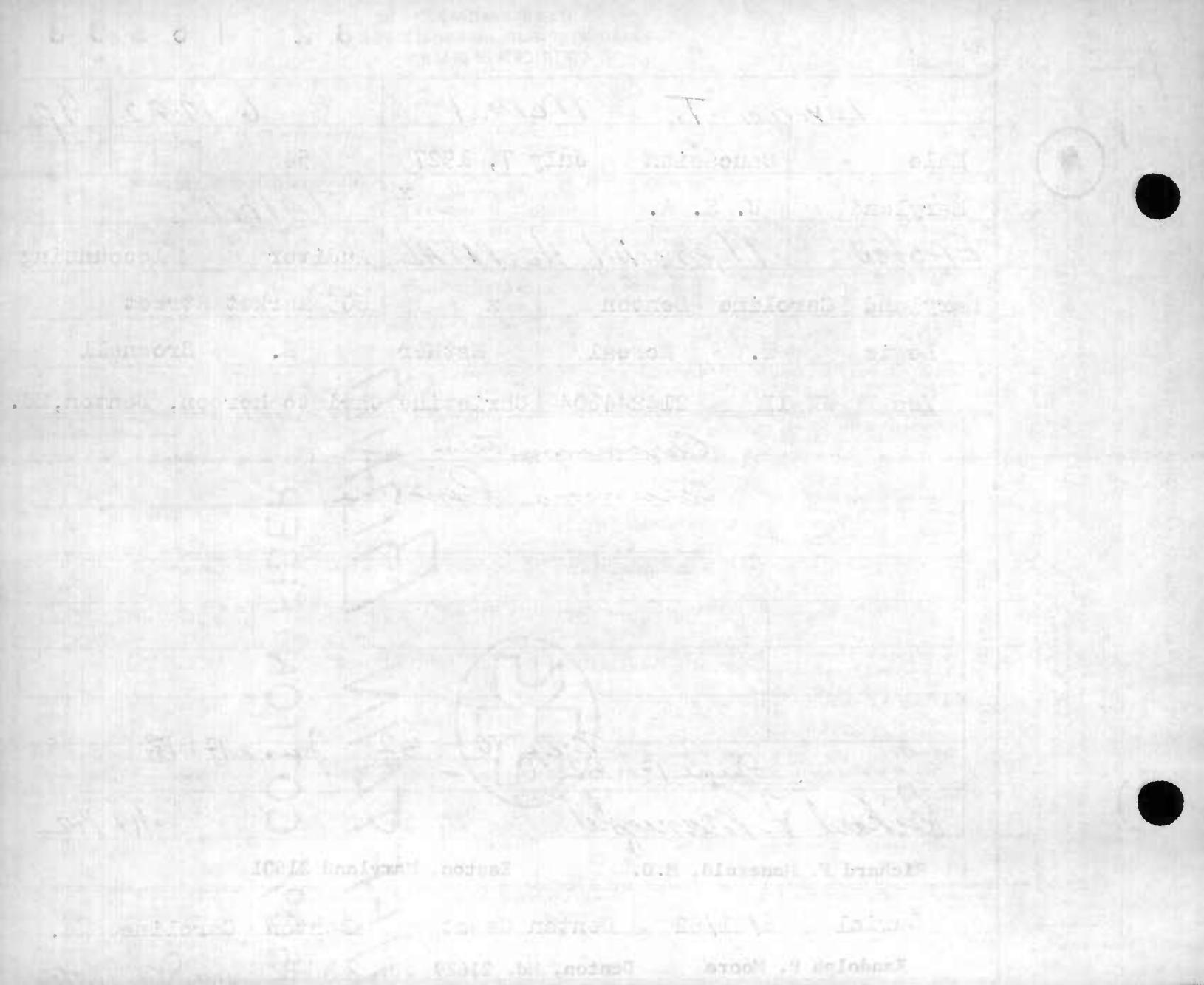
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If you are unable to do so, please return it to the State Registrar.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician or the funeral director, it should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 6 5 0 3				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	3b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
Laverne T. McNeal								July 7, 1927		54				
3. SEX			4. RACE			5. DATE OF BIRTH			7. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Male			Caucasian			Month Day Year			54					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Talbot		
Maryland			U. S. A.									MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
EASTON			Memorial Hospital			Auditor			Accounting					
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
14. STATE Maryland			13b. COUNTY Caroline			Denton			805 Market Street					
14. FATHER'S NAME Lewis			15. MOTHER'S MAIDEN NAME T. McNeal			16. SOCIAL SECURITY NO.			17. INFORMANT					
FIRST Lewis			FIRST Esther			214244604			ADDRESS					
MIDDLE T.			MIDDLE E.						Christine Christopherson, Denton, Md.					
LAST			LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Yes			WW II											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110.											
1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110.											
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatous Carcinoma Pancreas.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from May 10, 1982, to June 17, 1982, that (I) (we) last saw the deceased alive on June 17, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									COUNTY					
22b. SIGNATURE Richard F. Manegold			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			STATE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold, M.D.			22e. ADDRESS			Easton, Maryland 21601			22f. DATE SIGNED 6/18/82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/21/82			23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery			23d. LOCATION CITY OR TOWN Denton					
24. FUNERAL DIRECTOR NAME Randolph P. Moore			ADDRESS Denton, Md. 21629			25a. DATE REC'D. BY REGISTRAR JUN 23 1982			25b. REGISTRAR'S SIGNATURE James Van Winkle					
DHMH - 16 SOM 1/B1 (VRA 15, 4)														



10012 January 1962

J.H. Blasenbach & Bindel

Carrie Parker, Royal V. Johnson

State of California, Dept. of Justice

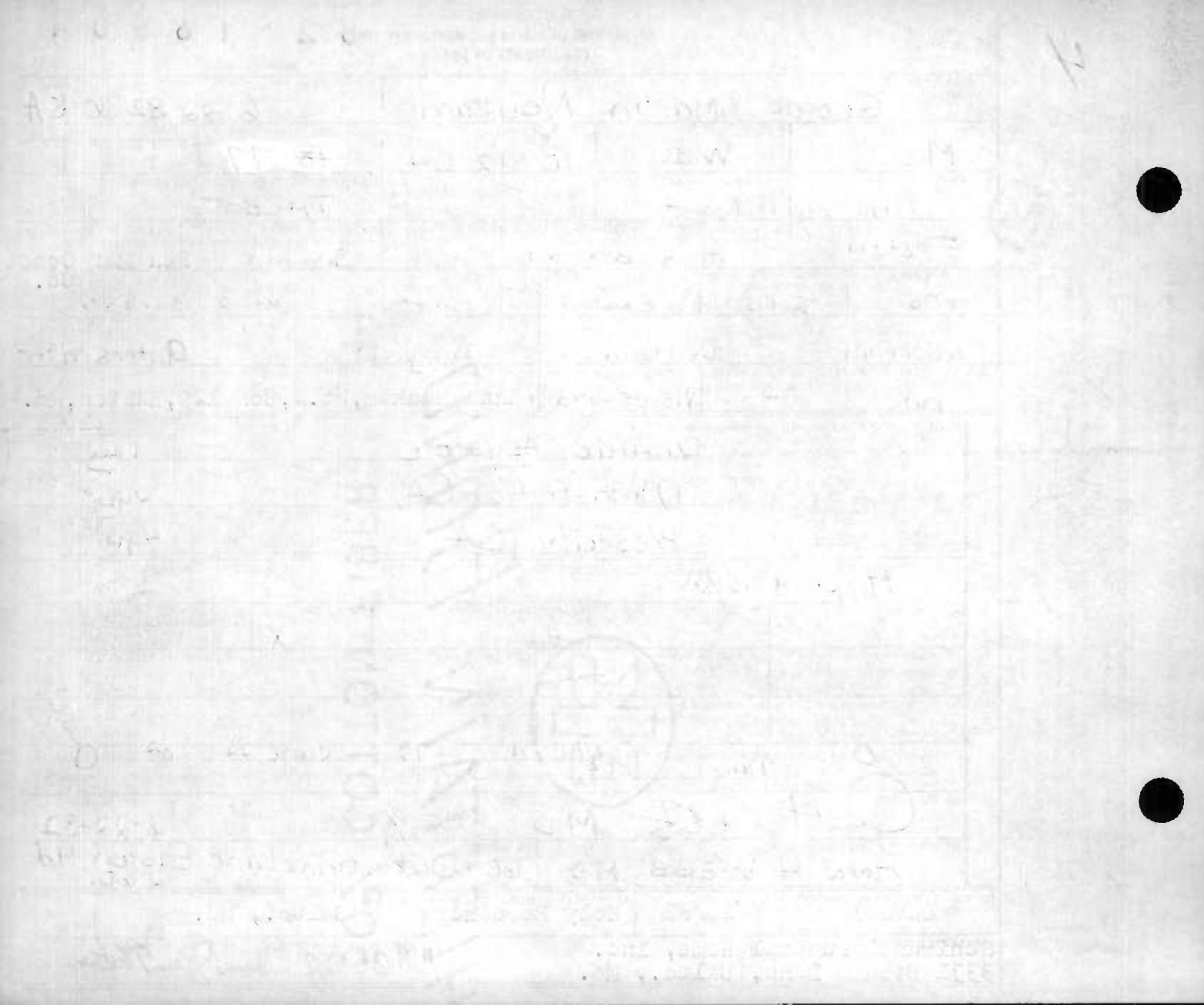
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 2 1 6 5 0 4						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
George Martin Neukam												6 22 82					1045 A.M.	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 10 DAY 12 YEAR 04			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.									
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2 Box 129			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Pen Mar Const Co.									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md Talbot			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 2 Box 129						
14. FATHER'S NAME First Lawrence Middle Neukam Last			15. MOTHER'S MAIDEN NAME First Margaret Middle Last Antersreiter															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. - 215-05-8430			17. INFORMANT Anna Neukam, Rt. 2, Box 129, Easton, Md.			ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Asystole 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic CA (c) Prostatic CA												APPROXIMATE TIME BETWEEN ONE CAUSE 1 day 2 yrs. 4 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hyper tension																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) May 1982			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from Nov 11, 1977, to June 22, 1982, that (I) (we) last saw the deceased alive on May 1, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 6-22-82						
22b. SIGNATURE Q. H. Webb M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANN H. WEBB, M.D.			22e. ADDRESS 607 Dutchmans Lane, Easton Md. 21601															
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 6/24/82			23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer			23d. LOCATION Balto., Md. COUNTY STATE									
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md.			25a. DATE REC'D. BY REGISTRAR JUN 25 1982			25b. REGISTRAR'S SIGNATURE James Jan Kithen												



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 6 5 0 5

REG. NO.

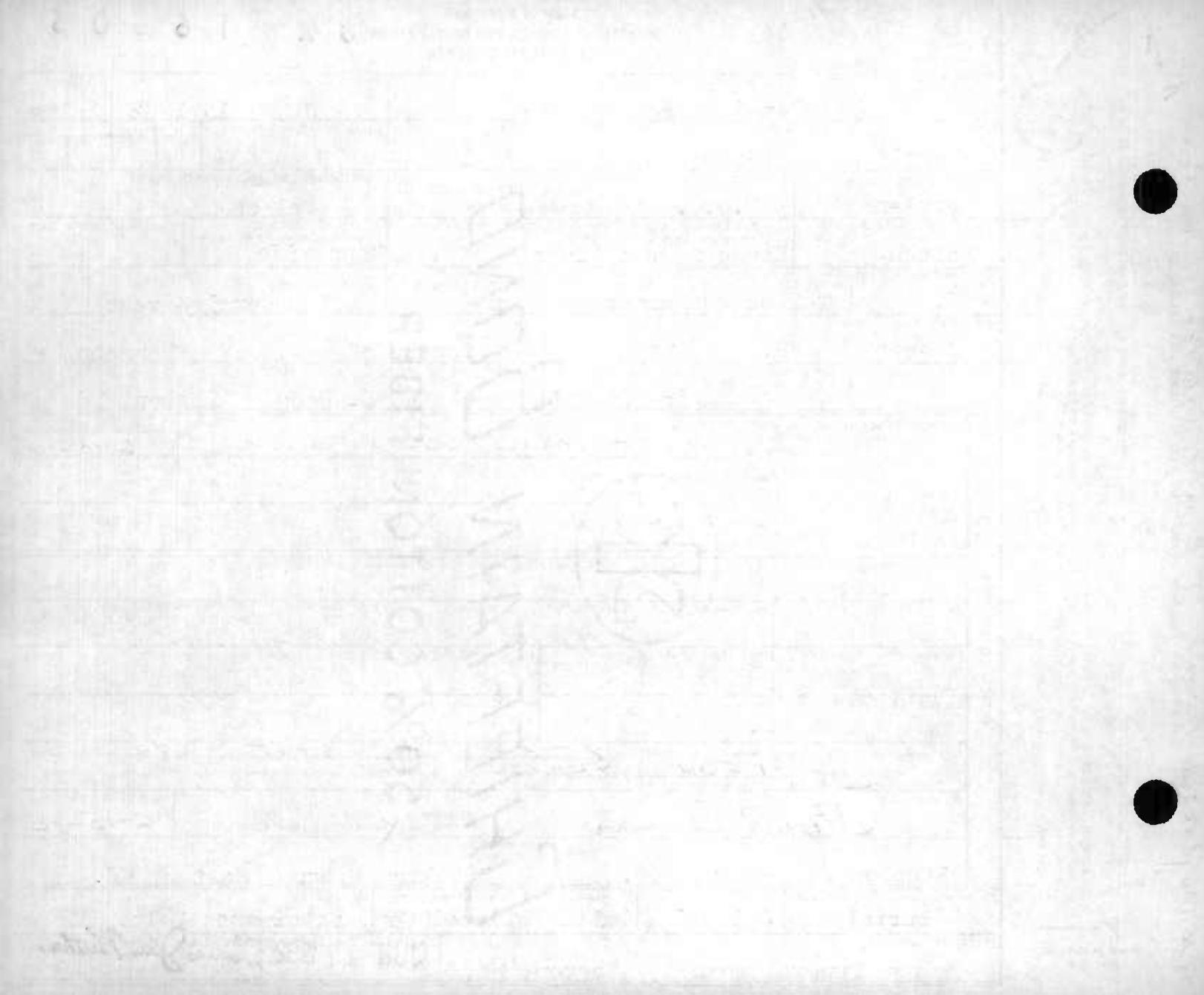
1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Magdalena Irene Novak						JUNE 15 1982			2:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS			
Female		Caucasian		MAY 6 1903			79 YRS			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.					Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton		House in the Pines		Housewife									
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13a. STATE Md.	13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13e. STREET ADDRESS 201 Federal Street										
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Joseph H. Fallin			Gertrude B. Thompson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
(If Yes, give war or dates)			216-03-6693			Madelaine L. Wood			Easton, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC COLON CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1539 64 yrs													
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-3, 1980, to 6-15, 1982, that (I) (we) last saw the deceased alive on 1 JUN 82, and shot in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-15-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			Dutchman's Lane Easton, Md.								
Stephen P. Carney, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY				
Burial		6-17-82		Balt. National Cem.			Baltimore		Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR / REGISTERED JUN 17 1982 Since Jan Nathan								
Newnam Funeral Home		Easton, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	5	0	6
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Henrietta M. O'Hare						6-04-82						957 AM						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White			MONTH DAY YEAR			92 YRS			MONTHS	DAYS	HOURS	MIN			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
West Virginia			U.S.A.						Talbot									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Easton			Memorial Hospital			Housewife												
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS									
Maryland			Queen Anne Stevensville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Love Point Road									
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
John Unknown Moore						Elizabeth					Serig							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			212-74-6649			Mary Louise Rosendale; Stevensville, Md.												
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure (bilateral)</i> <i>4292</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary artery disease</i> (c) <i>atherosclerotic CV disease</i> <i>years</i> years																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>cardiovascular disease = chronic brain syndrome = dementia</i>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
—						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/4/82</i> , 19 <i>82</i> , to <i>6/4/82</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>6/4/82</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			<i>6/4/82</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
Albert T. Hawkins Jr.			14 N. Aurora St															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE					
Burial			June 7, 1982			Holy Redeemer			Baltimore			Baltimore City	Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Helen Berlin-Husband			Chester Rd.			JUN 9 1982			Helen Berlin-Husband									

Another student
and the present
writer has written to

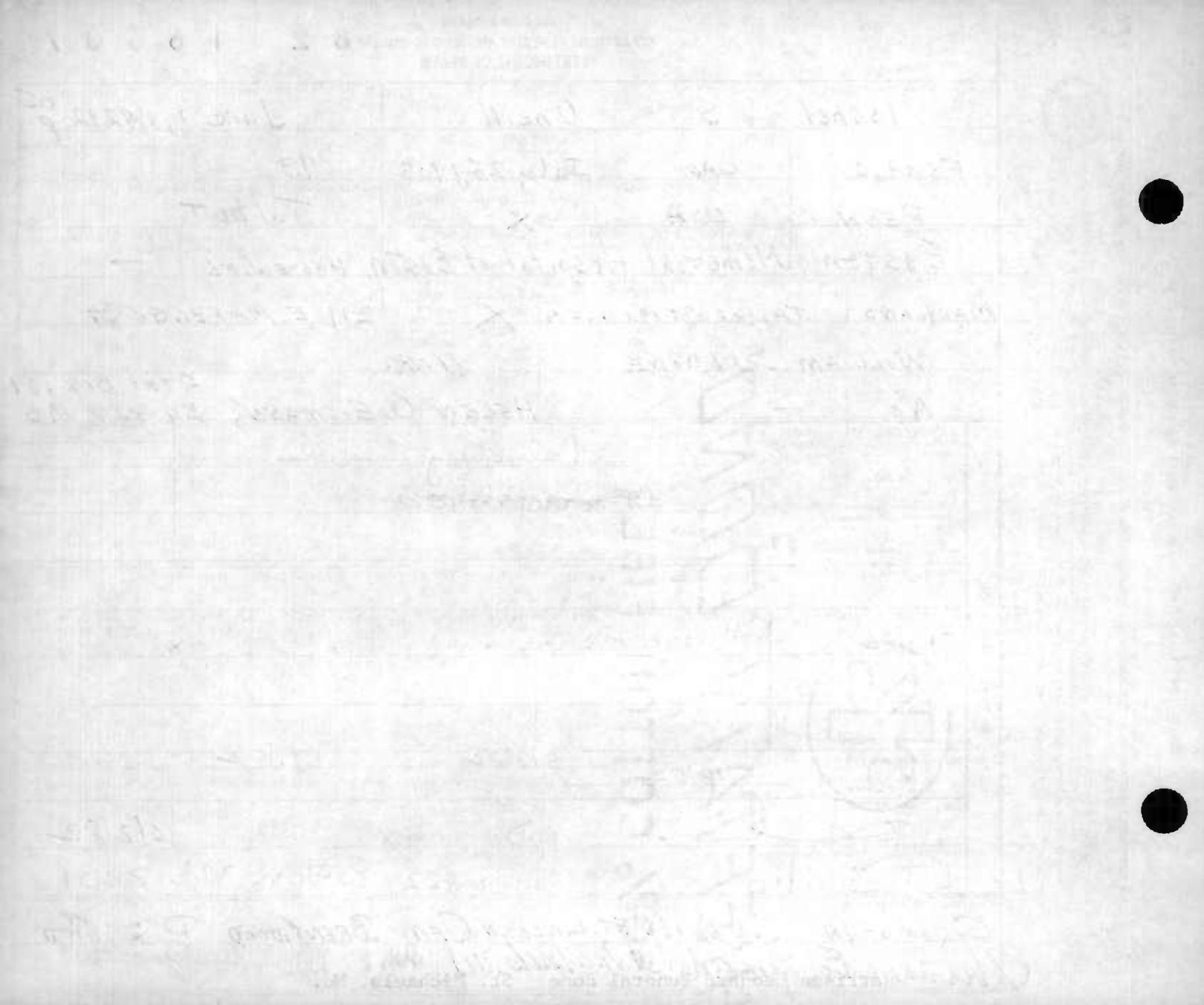
(Authorised by Dr. T. G. D.)

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IMPORTANT: If item 21 is marked as in Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 6 5 0 7 CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR
Isabel S O'Neill						June 1, 1982			12	05	
2. SEX			3. RACE			4. DATE OF BIRTH			5. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE			CAV.			July 25, 1908			73		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot		
Penn			USA						MD.		
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. STATE MARYLAND			13b. COUNTY TALBOT			13c. CITY OR TOWN St. Michaels			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME William Spadene						15. MOTHER'S MAIDEN NAME Link			13e. STREET ADDRESS 211 E. MARENGO ST.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. —			17. INFORMANT HELEN O. EISMANNS			ADDRESS RT#1, Box 171 EASTON MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4519 Pulmonary Emboli APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombophlebitis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 5/10/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atherosclerosis			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 5/18/82					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5/28/82			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			6/1/82 19		
22a. I certify that (I) (this hospital) attended the deceased from 5/18/82, 19, to 6/1/82, 19, that (I) (we) last saw the deceased alive on 5/28/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L.T. Diilio			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 6/1/82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE Jun 2, 1982			23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEM.			23d. LOCATION CITY OR TOWN BRENTWOOD		
24. FUNERAL DIRECTOR NAME Harrison Leonard			ADDRESS Leonard Funeral Home			25a. MANNER OF DEATH 1982			25b. REGISTERED BY REGISTRAR D.G. MD.		
25c. ADDRESS St. Michaels, Md.											

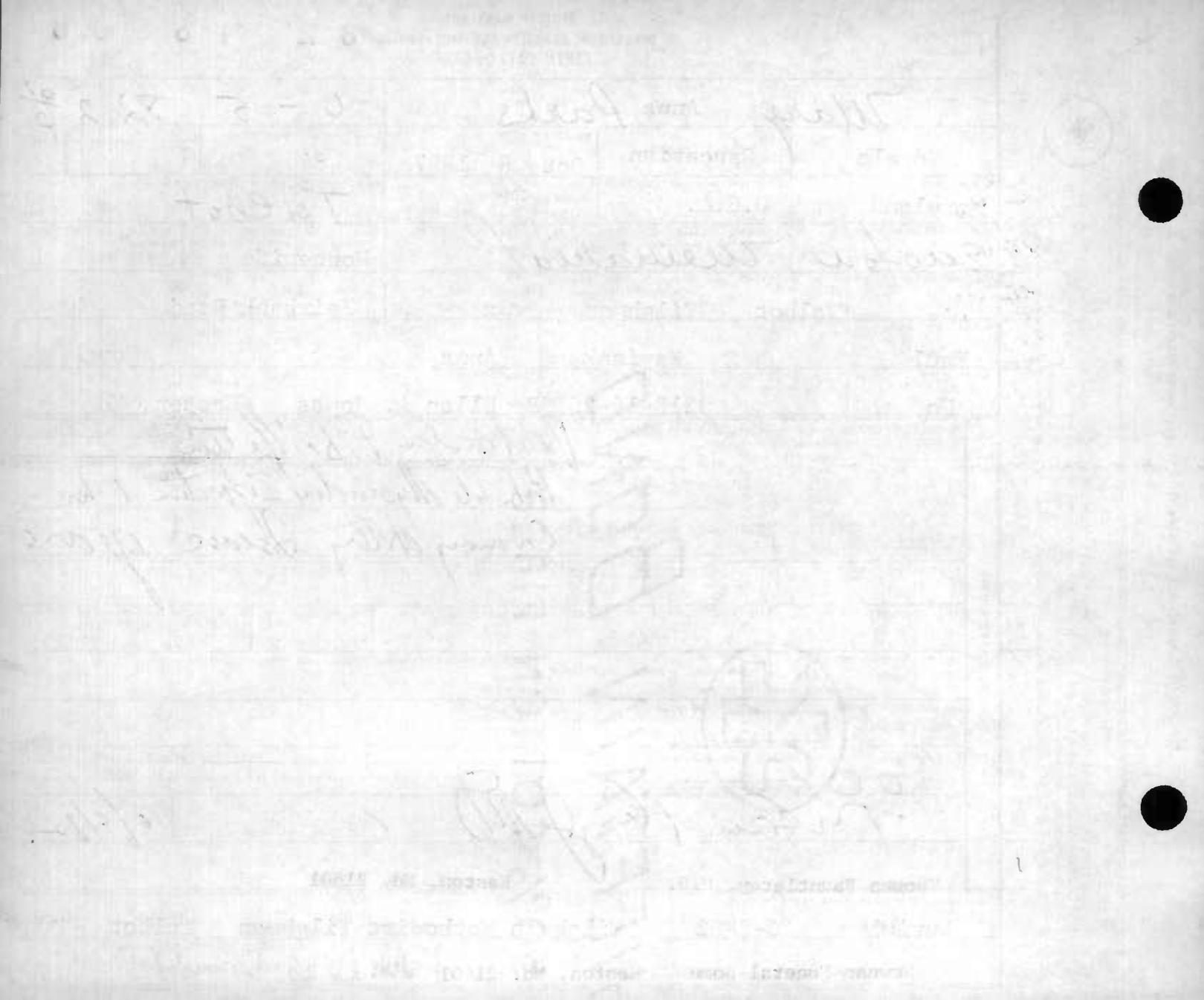


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	1 6 5 0 8		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>Mary</i>			<i>Anna</i>	<i>Parts</i>		<i>6 - 5</i>			<i>82</i>	<i>3 07</i>	<i>PM</i>				
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Caucasian	MONTH	DAY	YEAR	84	YRS	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			U.S.A.						<i>Talbot</i>						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>Easton</i>			<i>Sequoia</i>			<i>Housewife</i>									
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Md.			Talbot	Tilghman				Fairbank Road							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
<i>Paul</i>					<i>Kapisak</i>	<i>Anna</i>					<i>Novak</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			218-16-2589B			Ellen A. Jones			Easton, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Probable Myocardial Infarction 1 hr. Coronary Artery Disease years															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														22c. DATE SIGNED <i>6/6/82</i>	
22b. SIGNATURE <i>Thomas Fauntleroy MD</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas Fauntleroy, M.D.</i>			22e. ADDRESS <i>Easton, Md. 21601</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>Burial 6-8-82</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Tilghman Methodist</i>			23d. LOCATION CITY OR TOWN <i>Tilghman Talbot</i>			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME			ADDRESS <i>Newnam Funeral Home Easton, Md. 21601</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 10 1982</i>			25b. REGISTRAR'S SIGNATURE <i>Thomas Fauntleroy</i>						



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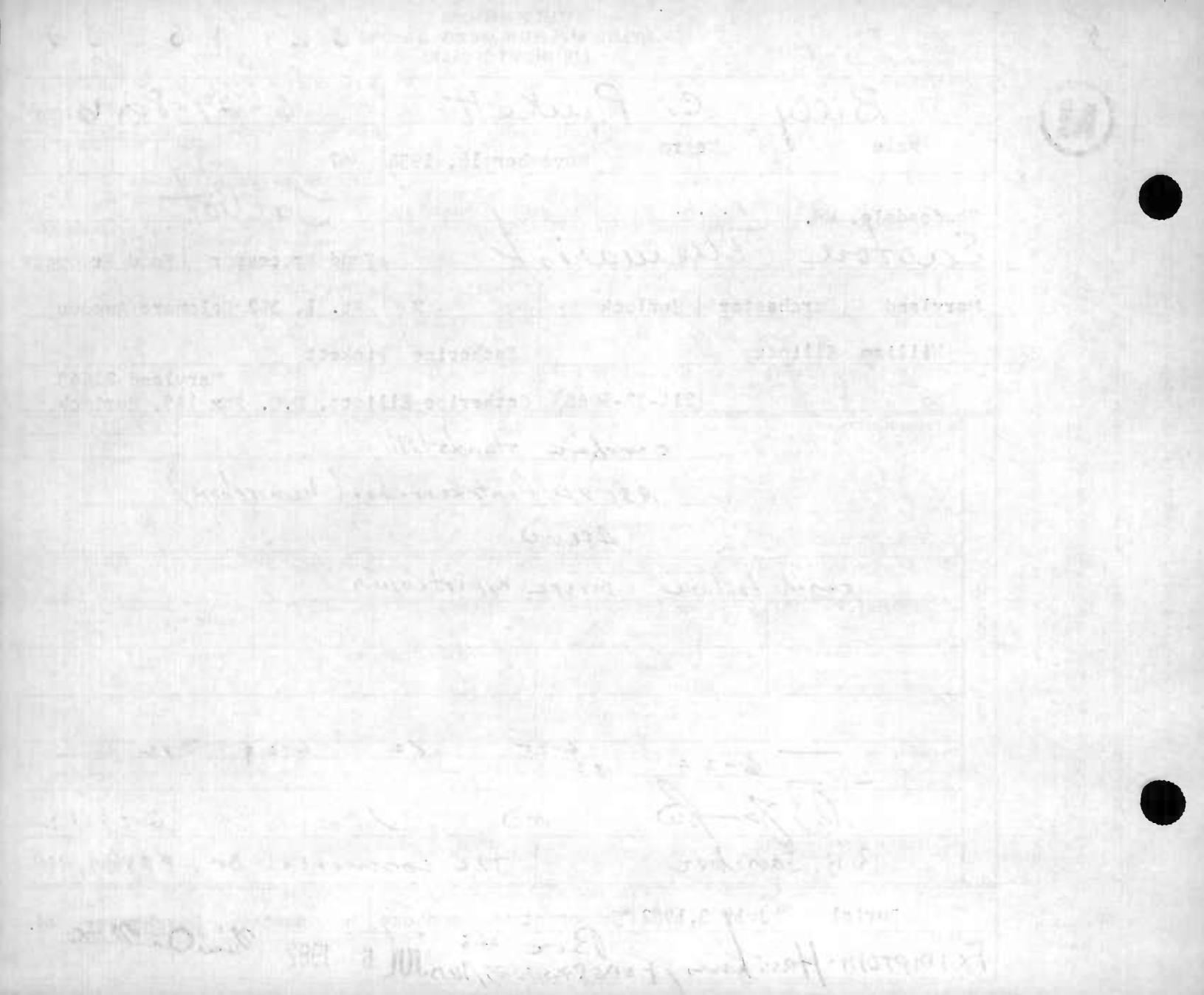
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 5 0 9		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
<i>Billy</i>			<i>C.</i>	<i>Pinkett</i>		<i>6-29-82</i>						<i>6:00PM</i>		
3. SEX		Male	4 RACE		Negro	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
						<i>November 18, 1934</i>			47	YRS		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Rhodesdale, Md.	7b. CITIZEN OF WHAT COUNTRY?		U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
10. CITY OR TOWN OF DEATH		<i>Easton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		<i>Delaware</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE		Maryland	13b. COUNTY		Dorchester	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
						<i>Hurlock</i>						<i>Rt. 1, 392 Delaware Avenue</i>		
14. FATHER'S NAME		William Elliott				15. MOTHER'S MAIDEN NAME								
						<i>Catherine Pinkett</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		No	16b. SOCIAL SECURITY NO.		214-32-5068	17. INFORMANT			ADDRESS			Maryland 21643		
						<i>Catherine Elliott, P.O. Box 145, Hurlock,</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <i>cardiac standstill</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		<i>4292</i>												
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVd (intracerebral hemorrhage)</i>												
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>45cvd</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>renal failure severe hypertension</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-28</i> , 19 <i>82</i> , to <i>6-29</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>6-29</i> , 19 <i>82</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>R.B. Sanchez</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6-29-82</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.B. Sanchez</i>			22e. ADDRESS <i>322 commerce Dr. Easton, MD</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 3, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Thompsonstown Cemetery			23d. LOCATION CITY OR TOWN Thompsonstown, Dorchester, Md.			COUNTY	STATE	
24. FUNERAL DIRECTOR <i>Franklin Hawkins, FEDERALSBG, MD</i>			NAME <i>Franklin Hawkins</i>			ADDRESS <i>Box 43, FEDERALSBG, MD</i>			25a. DATE REC'D. BY REGISTRAR JUL 6 1982			REGISTRAR SIGNATURE <i>Franklin Hawkins</i>		

5
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 inside back cover.

RETIRED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

BP _____
DHMH - 16 50M 1/81
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82	16510	
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR					
VIRGINIA H REED						6/15/82			1:30 PM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE			BLACK			Feb. 28 1930			52 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA			U.S.A.						TALBOT					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
EASTON			MEMORIAL HOSPITAL			OYSTER SHOCKER			Sea food Easton Bay					
13a STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS		
Maryland			Queen Anne			Chester						Route #1 Box 199		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT			Rt #1 Box 318C Chester, Md. 21619		
ROBERT H. REED			VIOLA V. JOHNSON			231-30-6803			Mrs. Elizabeth Stowers					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1629 carcinoma of left upper lobe due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (b) lung infection underlying cause lost.												months		
due to, or as a consequence of (b) see below the metastases												weeks		
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) respiratory failure + COPD														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 6/15/82 to 6/15/82, that (I) (we) last saw the deceased alive on 6/15/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			6/15/82		
Albert T. DAWKINS JR			MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. LOCATION CITY OR TOWN COUNTY STATE			22g. DATE REC'D. BY REGISTRAR			EASTON MARYLAND 21601		
Burial			6/15/82			Lively Hope Church Callao, Virginia 22435			Northumberland Co.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE			23e. REGISTRAR'S SIGNATURE		
Burial			6/15/82			Lively Hope Church Callao, Virginia 22435			Northumberland Co.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Eugene W. Lee King George Jr. M.C. Cemetery Card 41						JUN 23 1982			James Jan Walker					

82

DEPT OF DEFENSE

SCHOOL

EDUCATION

A.D.U.

ADMIRALTY

DOE AND DEPT OF DEFENSE

ARMED FORCES EDUCATION

DOE AND DEPT OF DEFENSE

DOE

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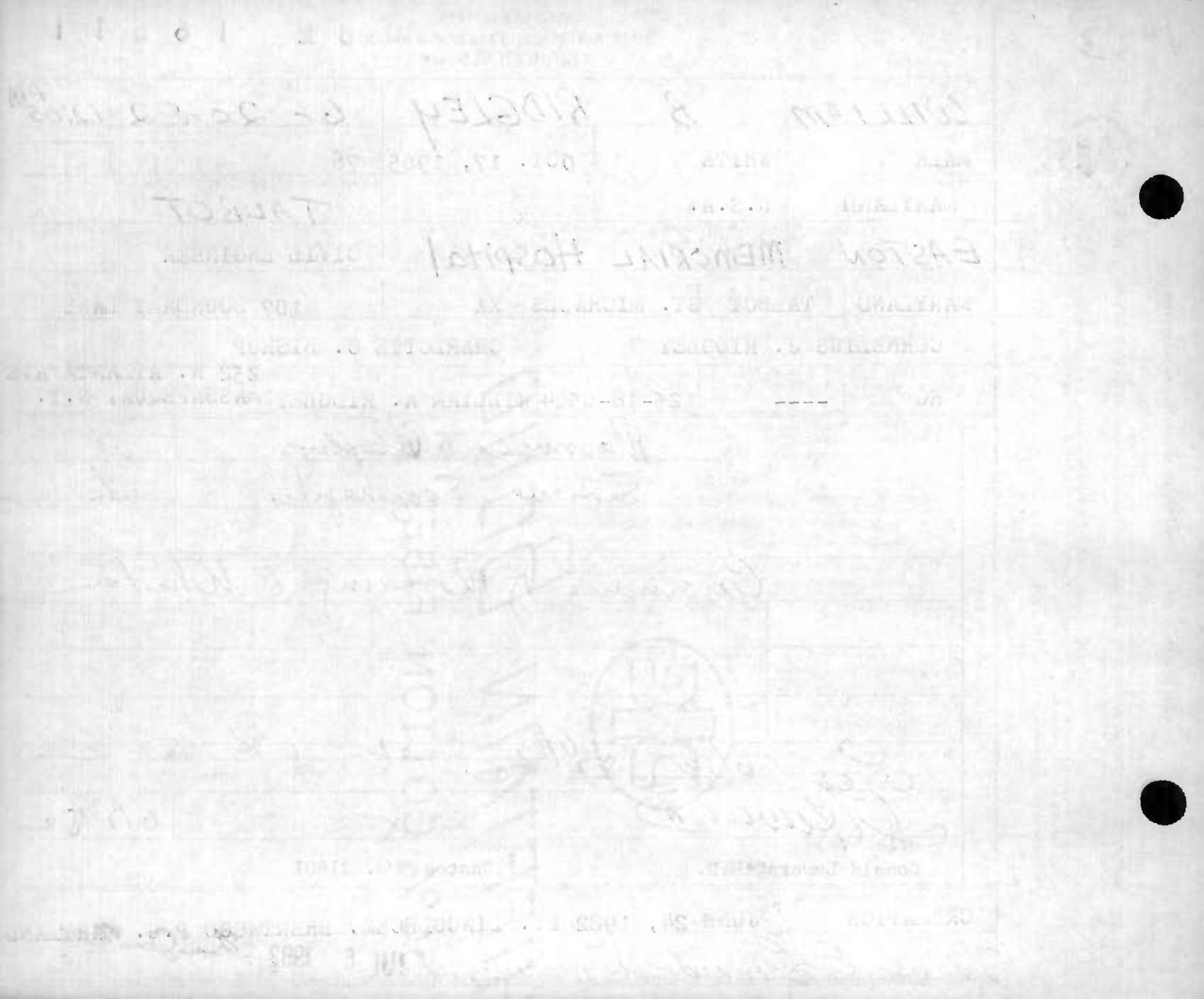
ON

ARMED FORCES EDUCATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 5 1 1		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
<i>WILLIAM B RIDGLEY</i>						<i>6-20-82</i>						<i>PM 12:05</i>		
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			WHITE	<i>OCT. 17, 1905</i>			76			MONTHS	YEARS	HOURS	MIN	
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND			U.S.A.						<i>TALBOT</i>					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
<i>EASTON</i>			<i>MEMORIAL Hospital</i>						<i>CIVIL ENGINEER</i>					
13a STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS						
MARYLAND			TALBOT	ST. MICHAELS				107 BOUNDARY LANE						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
CORNELIUS J. RIDGLEY			CHARLOTTE C. BISHOP											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
NO			125-18-0504			WILLIAM A. RIDGLEY			252 N. ATLANTA AVE MASSAPEQUA, N.Y.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY						IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
5308						<i>Mason C.J. Blodding</i>			wk					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) <i>Esophageal</i>			wk					
						(c) <i>Esophageal</i>								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1												<i>Carcinoma of the Lung c Metastasis</i>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. SURGICAL PROCEDURE			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) this hospital attended the deceased from <i>6/10/82</i> to <i>6/10/82</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <i>6/10/82</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated about the time of death and noted <input checked="" type="checkbox"/> the body after death.														
22b. SIGNATURE <i>D. Lewers</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/12/82</i>					
22d. ATTENDING PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald Lewers, M.D.</i>			22e. ADDRESS <i>Easton, Md. 21601</i>											
23a. BURIAL, CREMATION, REMOVAL REMOVED			23b. DATE <i>JUNE 24, 1982</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>FT. LINCOLNCE</i>			23d. LOCATION CITY OR TOWN <i>BRENTWOOD</i>			COUNTY	STATE	
CREMATION														
24. FUNERAL DIRECTOR NAME <i>Harmon E. Leonard St. Michaels Md</i>			ADD.			25a. DATE REC'D. BY REGISTRAR <i>JUL 6 1982</i>			25b. DISTRICT			<i>MARYLAND</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and completely fill in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

REMAINDER: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 6 5 1 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			Raequelle Roberts			June 1, 1982			1:45 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Caucasian		Sept. 5, 1895			86 yrs.						
7b. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
West Virginia		U. S. A.					Talbot			Easton			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
House in the Pines				Teacher				Education					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST			
Maryland		Caroline		Preston				Rt. 2 Box 185		James Singleton Raechel Robison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4409</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
		168074115		Mrs. Gene Engels, Ocean Pines, Md.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b)		DUE TO, OR AS A CONSEQUENCE OF <i>Severe generalized atherosclerosis</i>											
(c)		DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebral atrophy, dementia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from <i>4-20</i> , 19 <i>81</i> , to <i>6-1</i> , 19 <i>82</i> , that (I) we lost saw the deceased alive on <i>4-20</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Terry P. Detrich</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Terry P. Detrich, M. D.		140 S. Washington St., Easton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE	
Burial		6/4/82		Denton Cemetery		Denton		Caroline				Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS											
DANOLPH P. MOORE		DENTON, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Fingers may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 6 5 1 3 CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR
Clarence E. Roop.						6 13 82					11 AM
2. SEX			4. RACE			5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		
Male			White			Month Day Year April 3, 1914			If Under 1 Year 68 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD		
Federalsburg, Md.			U.S.A.								
10 CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gas Station Operator			12b. KIND OF BUSINESS OR INDUSTRY Oil Co.		
13a. STATE Maryland			13c. COUNTY Caroline			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 2, Box 119		
14. FATHER'S NAME Howard Roop						15. MOTHER'S MAIDEN NAME Roxana Williamson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-09-3111A			17. INFORMANT Dorothy W. Roop, Rt. 2, Box 119, Denton, Md.			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3429 BLOWN CITO PNEUMONIA 6/7/82 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last RIGHT HEART PARESIS 5/19/82											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. CARING MA POST ATE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6/13/82, 19, to 6/13/82, 19, that (I) (we) last saw the deceased alive on above, (I) (we) did not view the body after death.											
22b. SIGNATURE C. R. W. Bain MD		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6/13/82			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. W. Bain		22f. ADDRESS Easton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 16, 1982		23c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery			23d. LOCATION CITY OR TOWN Federalsburg, Caroline, Md.		24. FUNERAL DIRECTOR NAME Frampston-Hawkins - FEDERALSBURG		
									25d. DATE REC'D. BY REGISTRAR JUN 16 1982		
									REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	5	1	4								
												REG. NO.														
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR														
			MARIAN LAMB			Jands			June 25-82			1 AM M														
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.											
Female			Cau.			Aug 18, 1904			77 YRS																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Vermont			USA						TA160+			Easton			Memorial Hospital			Housewife			MD					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS														
Maryland			Talbot			Bozman																				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																							
Charles Oscar Lamb			Junie Tomlinson																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No ---			281-36-8525			William R. Sands Englewood, Colorado			1749			Metastatic Carcinoma			mos			1749			Carcinoma of the Breast			mos		
18. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			18. DUE TO, OR AS A CONSEQUENCE OF Carcinoma of the Breast			(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												Diabetes mellitus & tuberculosis														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that (if in this hospital) attended the deceased from <u>6/24</u> , 19 <u>82</u> , to <u>6/25</u> , 19 <u>82</u> , that (if we) last saw the deceased alive on <u>6/24</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I did/did not view the body after death.																										
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED																	
Donald Lewers, M.D.									Easton, Md. 21601																	
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY			STATE											
Burial			June 30, 1982			Edgewood Mem Pk			Wawa			Pennsylv														
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D. & REG'D. IN DEATH REGISTRY																				
Leonard E. Leonard, St. Michaels Rd						JUL 6 1982																				

REPORT OF THE

DEPT.

CLIMATE

JULY 19

ELIMINATION

NUMBER TOTAL BNFYRS

NOVEMBER 1976
JULY 1976

NUMBER TOTAL BNFYRS

NUMBER TOTAL BNFYRS

NUMBER TOTAL BNFYRS

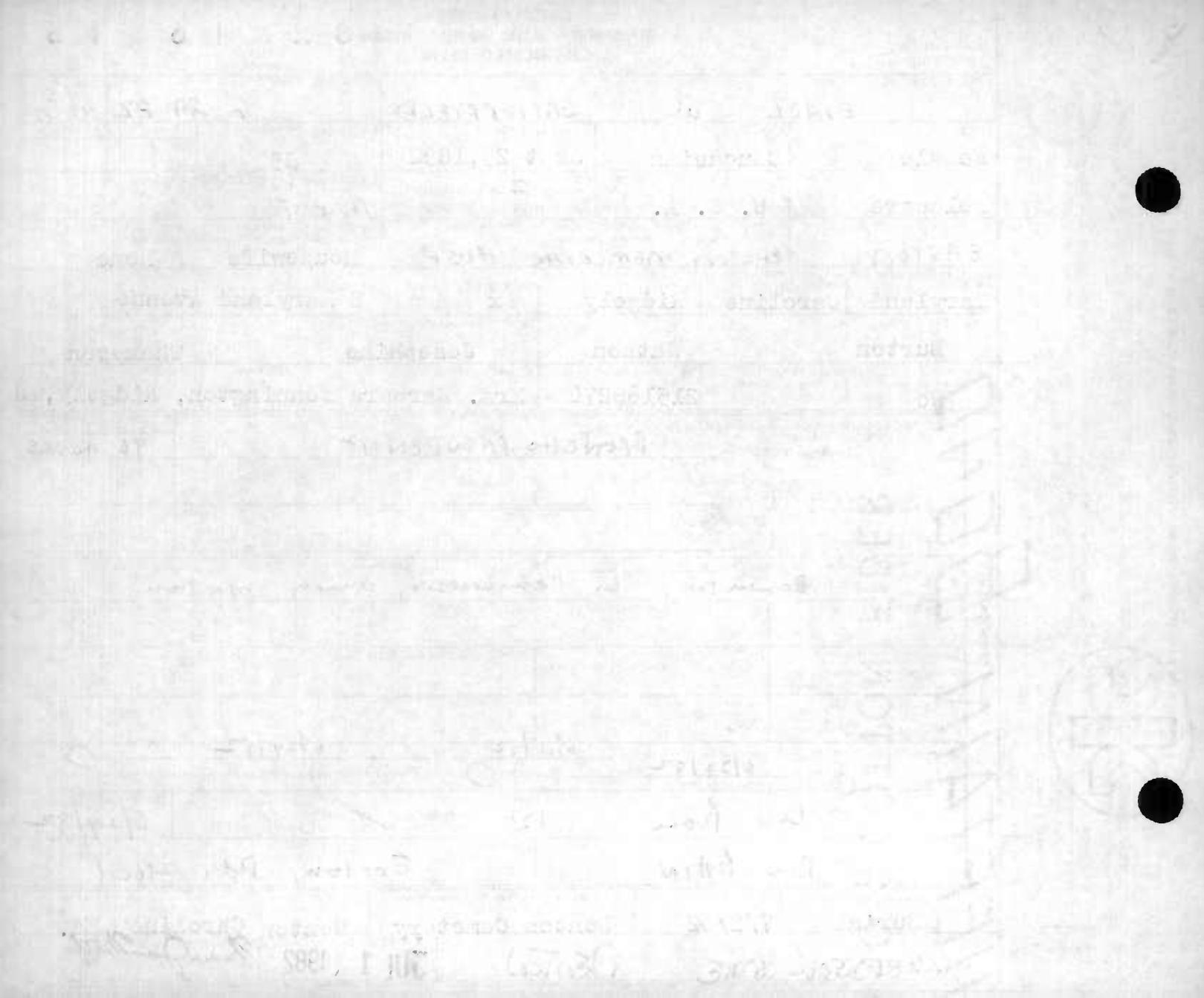
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 6 5 1 5 CERTIFICATE OF DEATH													
1 - FOR STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR 10 AM	
ETHEL W. SATTERFIELD						6 29 82						10 AM	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		Caucasian			Sept 29, 1892			89			MONTHS	DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS.		
Delaware		U. S. A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			TALBOT					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
EASTON		EASTON MEMORIAL HOSP.						Housewife			Home		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Caroline		Ridgely					8 Maryland Avenue				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
		Burton		Watson	Josephine								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		215168276			Mrs. Barbara Bennington, Ridgely, Md			96 HOURS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Moncto pneumonia</i>													
4850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Dementia, L. Hemiparesis, urinary incontinence</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/11/82</i> , 19_____, to <i>6/29/82</i> , 19_____, that (I) (we) lost saw the deceased alive on <i>6/28/82</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>C. W. Bain</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>6/29/82</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. W. Bain</i>		22e. ADDRESS <i>Eoston, Rd. 2601.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>8/2/82</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Denton Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Denton</i>			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>Moore Funeral Home</i>		ADDRESS <i>Denton</i>			25. DATE REC'D. BY REGISTRAR <i>JUL 1 1982</i>			26. REGISTRATION SIGNATURE <i>James J. Miller</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	1	6	5	1	6
										REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			<i>Catherine D. Smith</i>						<i>6-10-82</i>			<i>6^{PM}</i>				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS				
<i>Female</i>			<i>Caucasian</i>			<i>Dec. 9, 1897</i>			<i>84</i>			IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Maryland</i>			<i>U. S. A.</i>						<i>Talbot</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT A HOME FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>Easton</i>			<i>Memorial Hospital</i>			<i>Housewife</i>			<i>Home</i>							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
<i>Maryland</i>			<i>Caroline</i>			<i>Ridgely</i>						<i>Rt. 1 Box 61H Central Avenue</i>				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
<i>Frank</i>			<i>Davis</i>			<i>Harriet</i>						<i>Casey</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>No</i>			<i>216167153D</i>			<i>Mrs. Beverly Willin, Ridgely, Md.</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> {uncertain DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>None</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that <i>(this hospital)</i> attended the deceased from <i>5-17</i> , 19 <i>82</i> , to <i>6-10</i> , 19 <i>82</i> , that <i>(I/we)</i> last saw the deceased alive on <i>6-10</i> , 19 <i>82</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>(I/we)</i> did <i>(did not)</i> view the body after death.																
22b. SIGNATURE <i>Robert W. Trever, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <i>6-12-82</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert W. Trever, M. D.</i>			22e. ADDRESS <i>RD3 Easton, Md. 21601</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/4/82</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Denton Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Denton</i>			COUNTY STATE <i>Caroline</i>				
24. FUNERAL DIRECTOR NAME <i>MOORE FUNERAL HOME DENTON MD</i>			ADDRESS			25. DATE REC'D. BY REGISTRAR <i>JUN 21 1982</i>			REGISTRATION NUMBER <i>16516</i>							

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FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

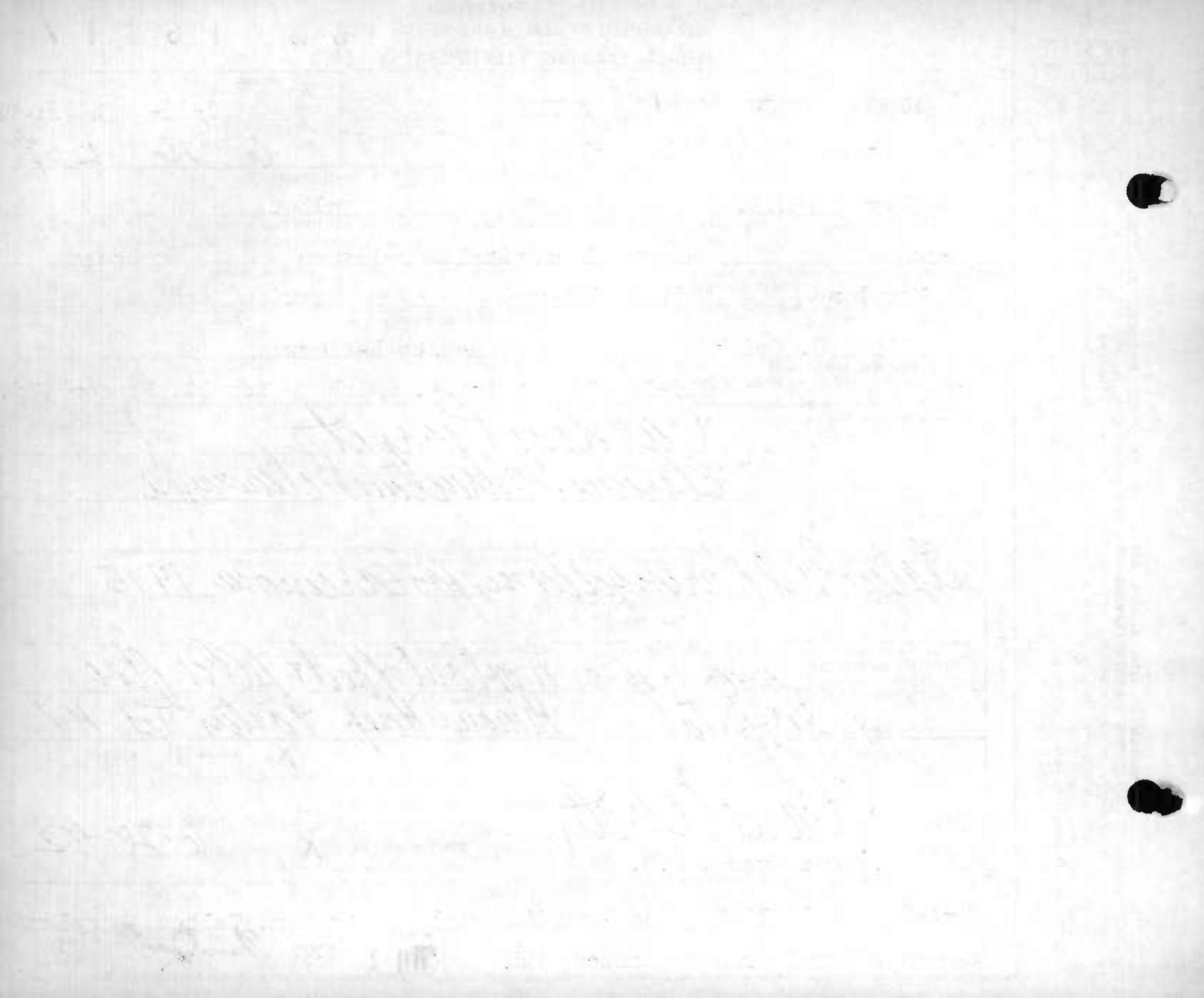
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 24 hours.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16517

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OF DEATH MATED	Month	Day	Year	2b. HOUR	
HENRY HINSON HOWARD SMITH				6-26-1982				5:40 P.M.	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	MIN		2d. HOUR	
male	white	11-13-1914	67						
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH						
New York	U.S.		Talbot						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Easton	Memorial Hospital				salesman			tobacco	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Maryland	Talbot	Newcomb	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Station Road					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
William G. Smith				Augusta Latimer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT	ADDRESS				
no	215-16-8746			Edith V. Smith	Box 13, Newcomb, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4960</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Cardiac Arrest Chronic Obstructive Pulmonary Disease</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Obesity with hypertension, for a necropsy, 1975</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6:00 P.M. 16 JUNE 1982			21c. HOW INJURY OCCURRED Enter nature of injury in Part X or Part 2, Item 18 <i>A gunshot wound & fall on floor.</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (at home, farm, street, factory, office, building, etc.) <i>Hospital</i>			21f. LOCATION Street or R.R. No. County Town <i>Memorial Hosp Easton St Hel</i>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>R. Lane Wroth</i>									
EXAMINER'S NAME (Type) R. Lane Wroth, M.D.									
M.D.									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
ADDRESS (Street, city, town, or county)									
22b. DATE SIGNED <i>6-28-82</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 6-29-1982			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial			
Burial						23d. LOCATION (City or Town) Easton, Talbot, Maryland			
24. FUNERAL DIRECTOR			ADDRESS Newnam Funeral Home			25a. REC'D BY REGISTRAR JUL 1 1982			
			Easton, Md.			25b. REGISTRAR'S SIGNATURE <i>Frankie Smith</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be notified and the death certificate may be held pending his/her examination.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	5	1	8
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
James					Charles Smith	6-23-82					1982	2:40 P.M.						
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			Cau.		MONTH Oct DAY 9, YEAR 1899			82			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			Talbot MD						
Mississippi			U. S. A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						
Easton			Memorial Hospital at Easton						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			Retired Carpenter					
Maryland			Caroline		Federalsburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			317 W. Central Ave.								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Charles			Perry		Smith	Emma			456-24-4084 A			Mrs. Eleanor Smith			Federalsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			ASystole												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			Myocardial Infarction												12 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED AT WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															22b. DATE SIGNED 6/27/82			
22b. SIGNATURE Thomas Fauntleroy, M.D.			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6/27/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
Thomas Fauntleroy, M.D.			Easton, Md. 21601															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 26			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest			23d. LOCATION CITY OR TOWN Federalsburg			COUNTY Car.		STATE Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 29 1982			25b. REGISTRATION SIGNATURE Tracy Jan Nathan									

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Medical Examiner *awore*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retd by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 6 5 1 9			
										REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			26. HOUR	
			Lester Stanton						6 17 82			1930 M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			26. HOUR IF UNDER 24 HRS HOURS MIN.	
male			B.I.K.			1 23 17			65 YRS				
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.	
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) Flemington Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY Talbot			13c. CITY OR TOWN EASTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Port St.	
14. FATHER'S NAME Clarance			15. MOTHER'S MAIDEN NAME Edna			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. _____			17. INFORMANT ROBERT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Coronavirus of the esophagus			(b) Pulmonary failure			6/10/82				
						(c)			6/17/82				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/17/82 to 19, 1982, that (I) (we) last saw the deceased alive on 19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Stanley Bysshe</i>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 6/17/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley Bysshe, M.D.			22e. ADDRESS Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-22-82			23c. NAME OF CEMETERY OR CREMATORIAL Ivy Town			23d. LOCATION CITY OR TOWN Easton Talbot Md.			23e. DATE REC'D. BY REGISTRAR JUN 24 1982	
24. FUNERAL DIRECTOR NAME George H. Dashiell Funeral Home			ADDRESS Easton			25b. REGISTRAR'S SIGNATURE <i>George H. Dashiell</i>							

0671-53

20 TUES 1 A/18 31pm
X A.2.11 6m

removed

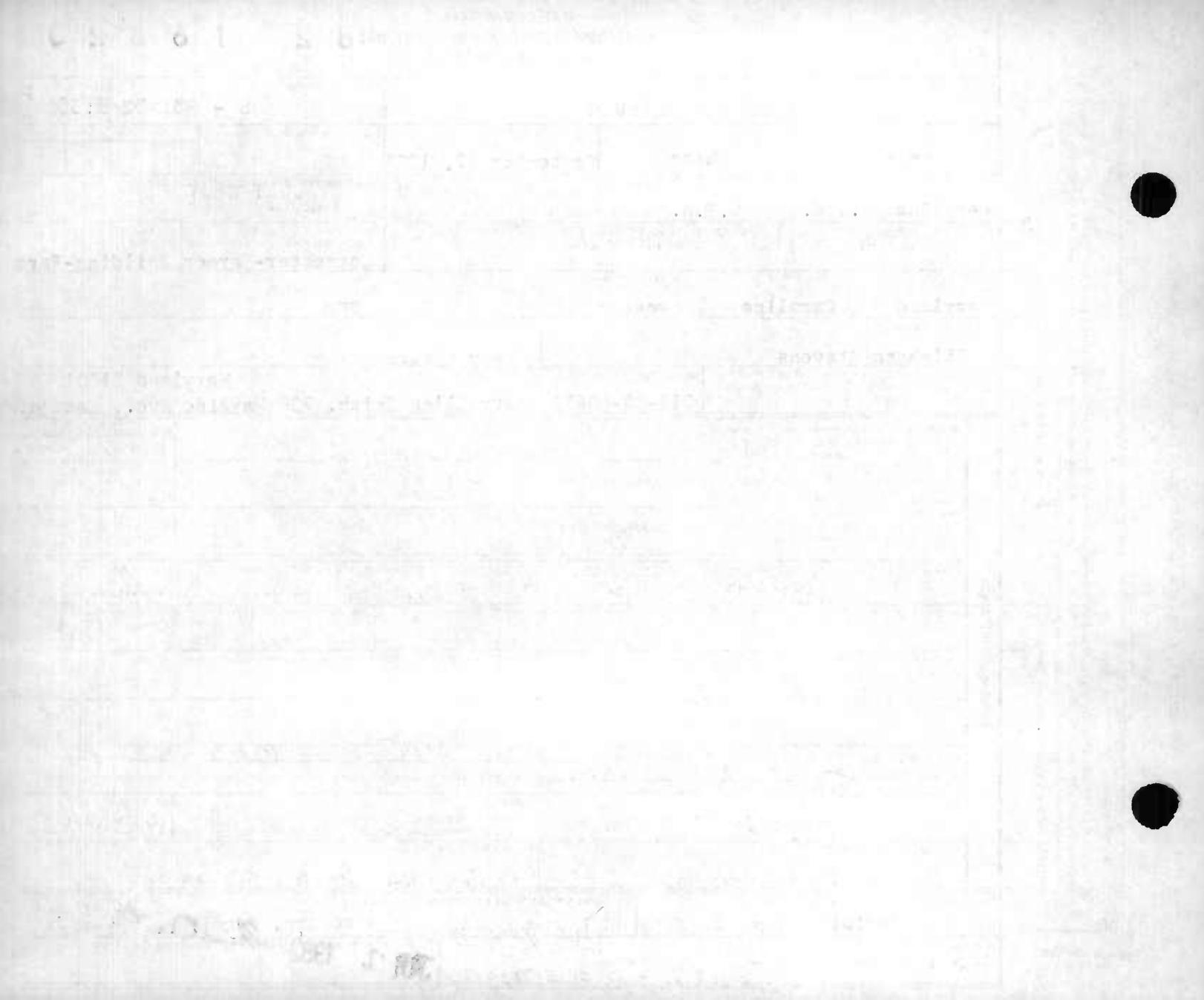
T2 Trop X noted Today .6m
red W on b3 noted — Gilmores
noted Trop — 0.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 5 2 0				
												REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				2d. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR		
			CARLTON STEVENS				6 - 23 82							P 5:35 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			September 17, 1901			80			MONTHS	YEARS	MONTHS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Caroline Co., Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT			MD.				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Hospital in MARYLAND			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter-Farmer			12b. KIND OF BUSINESS OR INDUSTRY Building-Farm							
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Preston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD				
14. FATHER'S NAME FIRST Tilghman Stevens			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Mary Cheezum			MIDDLE			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-05-8042A			17. INFORMANT Mary Ellen Smith, 739 Wayside Ave., Easton,			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4850 IMMEDIATE CAUSE (a) Bronchopneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day			ADDRESS Maryland 21601				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			DUE TO, OR AS A CONSEQUENCE OF			(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I ASCVS old cva & Basilar Artery Dissection																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (his hospital) attended the deceased from 6/11/1952 , to 6/23/1982 , that (I) (we) last saw the deceased alive on 6/11/1952 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.																
22b. SIGNATURE Donald T. Lewers, MD			DEGREE			ATTENDING PHYSICIAN Donald T. Lewers, MD			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/24/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Po Box 929 Easton, MD 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 26, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Junior Order Cemetery			23d. LOCATION CITY OR TOWN Preston, Carroll County, Maryland			24. FUNERAL DIRECTOR FRANCIS TOM HAWKINS, FEDERALSBURG				
												24e. DATE REC'D. BY MEDICAL DIRECTOR OR REGISTRAR'S SIGNATURE 1982				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	5	2	1
												REG. NO.						
1 - FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
			Elizabeth J. Steward						June 2 82			6 12 A.M.						
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
FEMALE			WHITE			APRIL 27, 1935			47			MONTHS DAYS						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS						
MARYLAND			U.S.A.						Talbot			YRS						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
SASTON			Memorial Hospital			HOUSEWIFE			HOUSEWORK									
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS									
MD.			CAROLINE GREENSBORO						R.D.1 BOX 461									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
HOWARD HAYMAN			ALICE BLOUGH															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
NO			217-30-9790			WILSON STEWARD			R.D.1 BOX 461 GREENSBORO, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 YRS</u>						
<u>1749</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1982</u> to <u>Aug 19, 1982</u> , that (I) (we) did not see the deceased alive on <u>Aug 1, 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Stephen P. Carney</u>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>6-2-82</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Stephen P. Carney, M.D.			22e. ADDRESS			Easton, Md. 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE						
BURIAL			6-5-82			DENTON CEMETERY			DENTON, CAROLINE, MD.									
24. FUNERAL DIRECTOR NAME			ADDRESS			25. STATE REC'D. BY (CHOICE TRANSFERRED TO CERTIFICATE SIGNATURE)			1982									
Lewis H. Jackman			50 COMMERCE ST. HARRINGTON, DE 19952															

СИ ЗЕРНО ДЛЯ СЕВА
Х

ДЛЯ ХОВ ТАКХ

НЕДОСТАВЛЕНИЕ ПРОДУКЦИИ ОБЯЗАТЕЛЬНО
ПРИЧЕМ КОМПАНИИ ПОДДЕРЖАТЬ

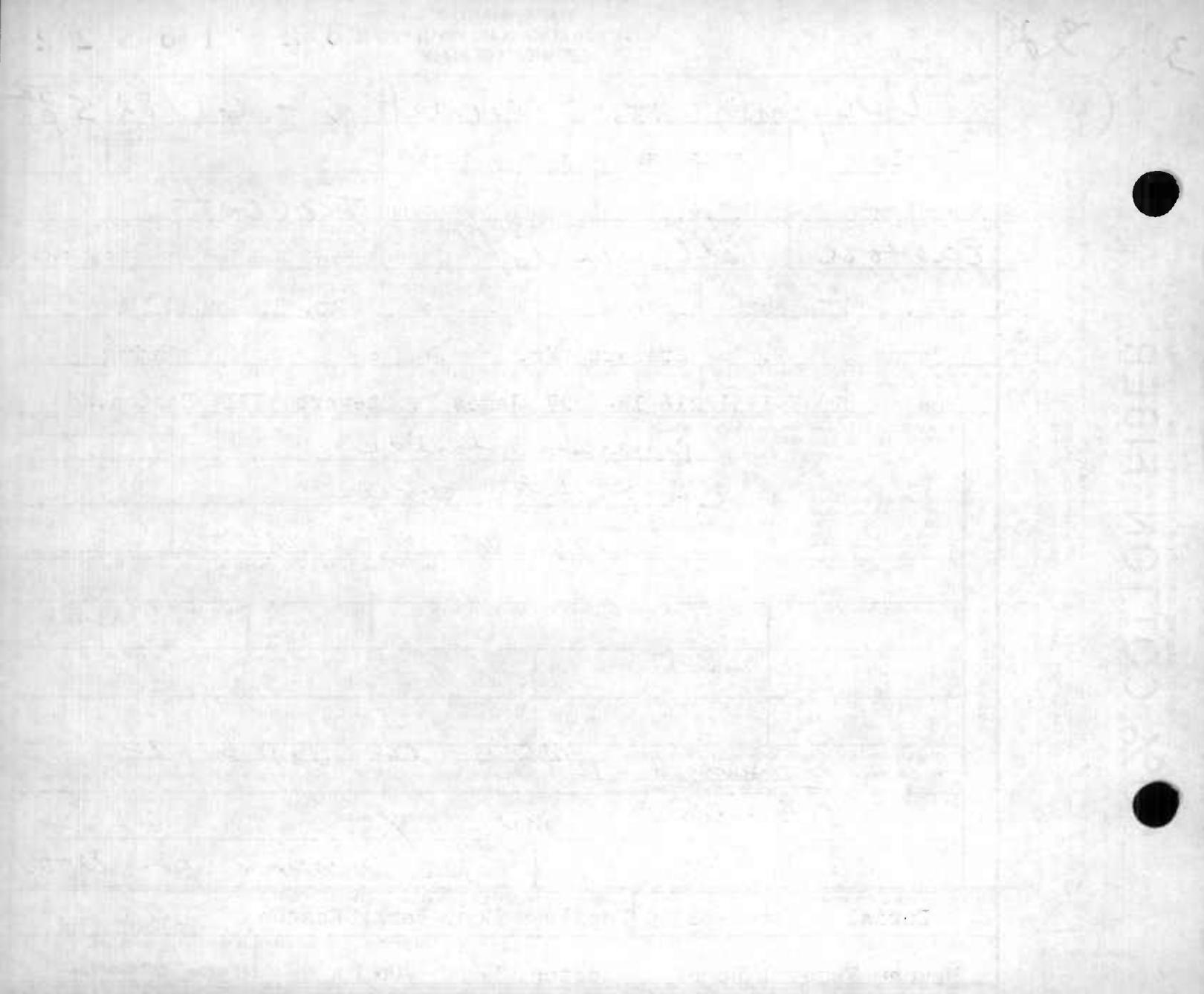
100% СЕРТИФИКАТЫ ОБРАЗОВАНИЯ И МАСТЕРСТВА

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82 16522		
												REG. NO.		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			JAN 28 1923			6-4 82 552 M			552		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			Caucasian			JAN 28 1923			59			YRS.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			U.S.A.						Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SURG. FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Woodlawn						Proof Reader			Publishing		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.			Talbot		Easton					Rt. 3, Box 679 A				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
James T. Stewart, Sr.			Josie V. Ewing											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes 1947-1951			216-18-8027			James T. Stewart, III			Easton, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			respiratory failure											
1579														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) metastatic cancer											
			(c) probable pancreatic cancer											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 13, 1982, to June 6, 1982, that (I) (we) last saw the deceased alive on June 6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE R.B. Sanchez			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-6-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.B. Sanchez			22e. ADDRESS 322 Commerce Dr. - Easton											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-9-82			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Mem. Park			23d. LOCATION CITY OR TOWN Easton			COUNTY Talbot	STATE Md.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR JUN 10 1982			25b. REGISTRAR'S SIGNATURE Janet J. Newnam					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 5 2 3				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	Sadie	MIDDLE	Theresa	LAST	STRINGER	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Sadie						Stringer			6-13-82					55	10 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 12 HRS		
Female			White			Month Day Year September 30, 1911			70			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD				
Maryland			USA						Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Eason			Memorial Hospital			Wife			Home							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Charles			Brandywine						R.D. #4, Box 106D				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
James			Osbourne			Brown Hardester			Sara			Theresa			Pfarr	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			R.D. #4, Box 106D				
No			218-70-4240			Son			William G. Stringer, Brandywine, Md. 20613							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>De q pancreas & wide spread</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>1579</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?				
(b) <i>rectosa & liver, peritonitis</i>																
(c) <i>?</i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12 pm</i> , 19 <i>82</i> , to <i>12 pm</i> , 19 <i>82</i> , that (I) (we) saw the deceased alive on <i>12 pm</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																
22b. SIGNATURE <i>Hurston Harrison</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/13/82</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HURSTON HARRISON</i>			22e. ADDRESS <i>EASTON MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 16, 1982			23c. NAME OF CEMETERY OR CREMATORIUM St. Peter's Cemetery			23d. LOCATION CITY OR TOWN Queenstown, Q.A.C.O., Md.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME James H. Barton, Jr. Barton Bros.			25a. DATE REC'D. BY REGISTRAR JUN 23 1982			25b. REGISTRAR'S SIGNATURE <i>Frances Jean Weston</i>										

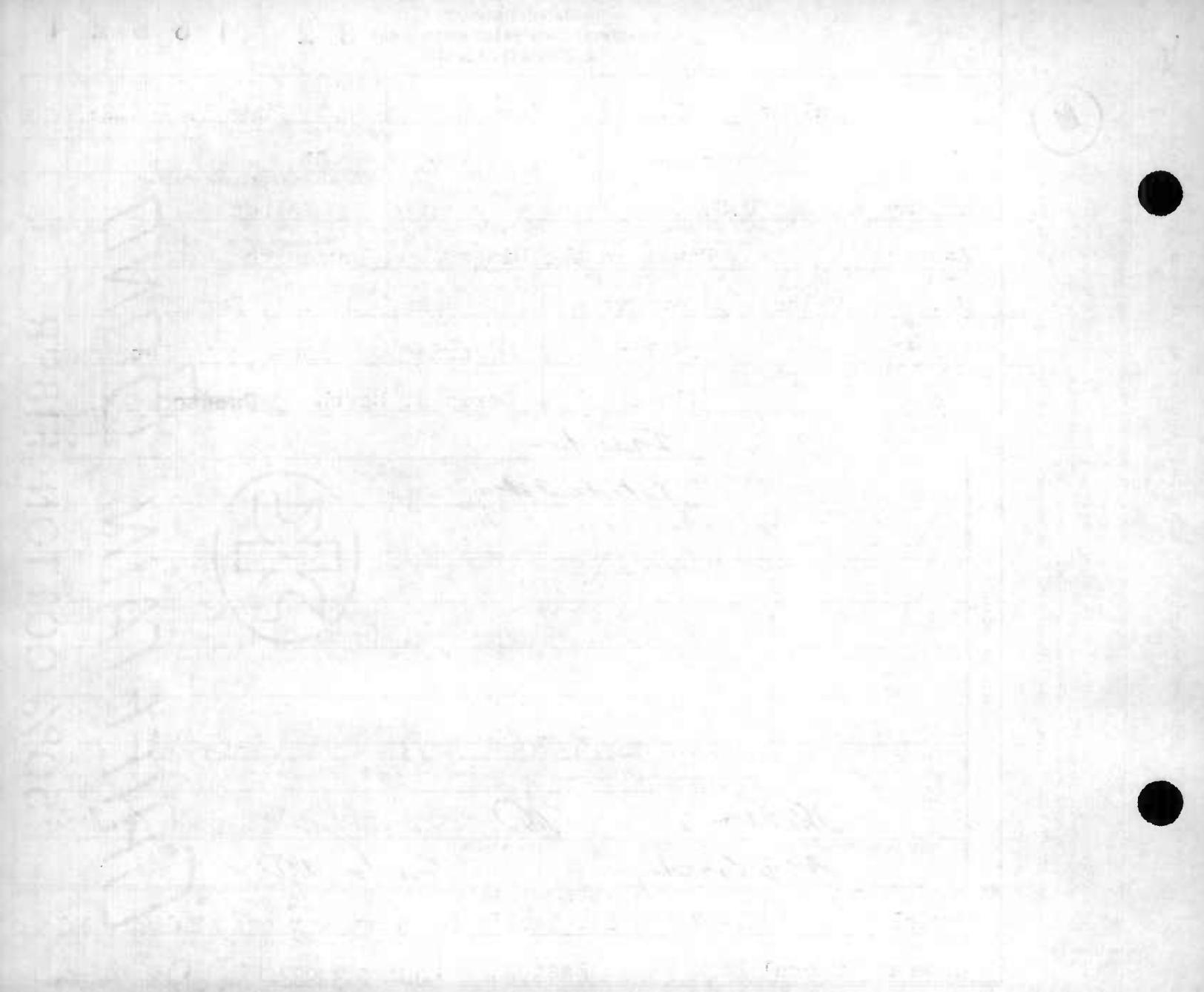
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 1 6 5 2 4	
1 - FOR STATE REGISTRAR						
I. DECEASED NAME (TYPE OR PRINT)		FIRST Pauline	MIDDLE K.	LAST Sump	2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR June 19 1982 2:30 a.m.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR NOV. 13 1900	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Md.		13b. COUNTY Talbot	13c. CITY OR TOWN Cordova	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.D. 1, Box 298	
14. FATHER'S NAME FIRST Leopold		MIDDLE Gysler	LAST Maria	FIRST Doris S.	MIDDLE Marth	
15. MOTHER'S MAIDEN NAME Hetzinger		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-28-3174	17. INFORMANT Preston, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Inanition		5698 IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Infectious disease				
		(c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 5-20 , 19 82 , to 5-13 , 19 82 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE M. D. Crowley		22c. DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 6-18-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. D. Crowley		22e. ADDRESS Easton, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-21-82	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery		23d. LOCATION CITY OR TOWN Cordova Talbot Md	STATE
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.	25a. DATE REC'D. BY REGISTRAR JUN 23 1982		25b. REGISTRAR'S SIGNATURE James Van Winkle	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do it now.
 f
 1 - STATE REGISTRAR
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 6 5 2 5		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
Naomi					Thomas		6-20-82		6	20	82	10 00 PM
3. SEX			4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 HRS	
Female			B.I.K.		M 22 7 20		61		MONTHS	YEARS	HOURS	MIN.
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Pa.			U.S.A.				Talbot					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton			Memorial Hospital				Domestic					
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md.			Talbot	Trappe			R#1 BOX 260					
14. FATHER'S NAME			FIRST	MIDDLE	15. MOTHER'S MAIDEN NAME		ADDRESS					
					fannie		N. freeman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) [IF YES, GIVE WAR OR DATES]			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for part 1b and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No					Meridie		Diffuse Bronchopneumonia		NK			
4850												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)									
			(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1b												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from now the deceased died on 6/20 1982 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death					6/20 1982		6/20 1982					
22b. SIGNATURE Dr. Lewis AD			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/21/82					
(NAME OF PHYSICIAN) (TYPE OR PRINT)					22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial			6-24-82	Paradise		Trappe		Talbot		Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Suzanne AD			Lutherville		JUN 24 1982		Jan. Johnson					
DHMH - 16 50M 1/81 (VRA 15, 4)												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. (Pages 1 thru 3 should be filed within 72 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, file a separate report.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 5 2 6								
												REG. NO.								
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			Earl F.			Todd Sr.						6			482			7:10 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 1 MONTH					
Male			Cau.			MONTH 5-25-04 DAY			YEAR			78			MONTHS					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Talbot			YRS					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						MD					
EASTON			Memorial			Tool & Die Maker Foundry														
13a. STATE Md.			13b. COUNTY Caroline			13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt 1 Box 82								
14. FATHER'S NAME FIRST Charles Todd MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST Kathryn MIDDLE LAST ?														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS											
no			217-07-4444			Patricia Aviles			Denton, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) Pancreatitis												Auto								
5770 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b)																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Atherosclerotic Cardiovascular Disease																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/4/82 to 6/4/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.																				
22b. SIGNATURE Greg Rhodes						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 6/7/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 400 Dutchman's Lane, Easton, MD 21601																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-8-82			23c. NAME OF CEMETERY OR CREMATORIUM Greensboro Cemetery			23d. LOCATION CITY OR TOWN Greensboro			COUNTY Caroline			STAFF					
24. FUNERAL DIRECTOR NAME John E. Bouldin Greensboro			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 14 1982			25b. REGISTRATION NO. 1000											
DHMH - 16 50M 1/81 (VRA 15, 4)																				

CONFIDENTIAL

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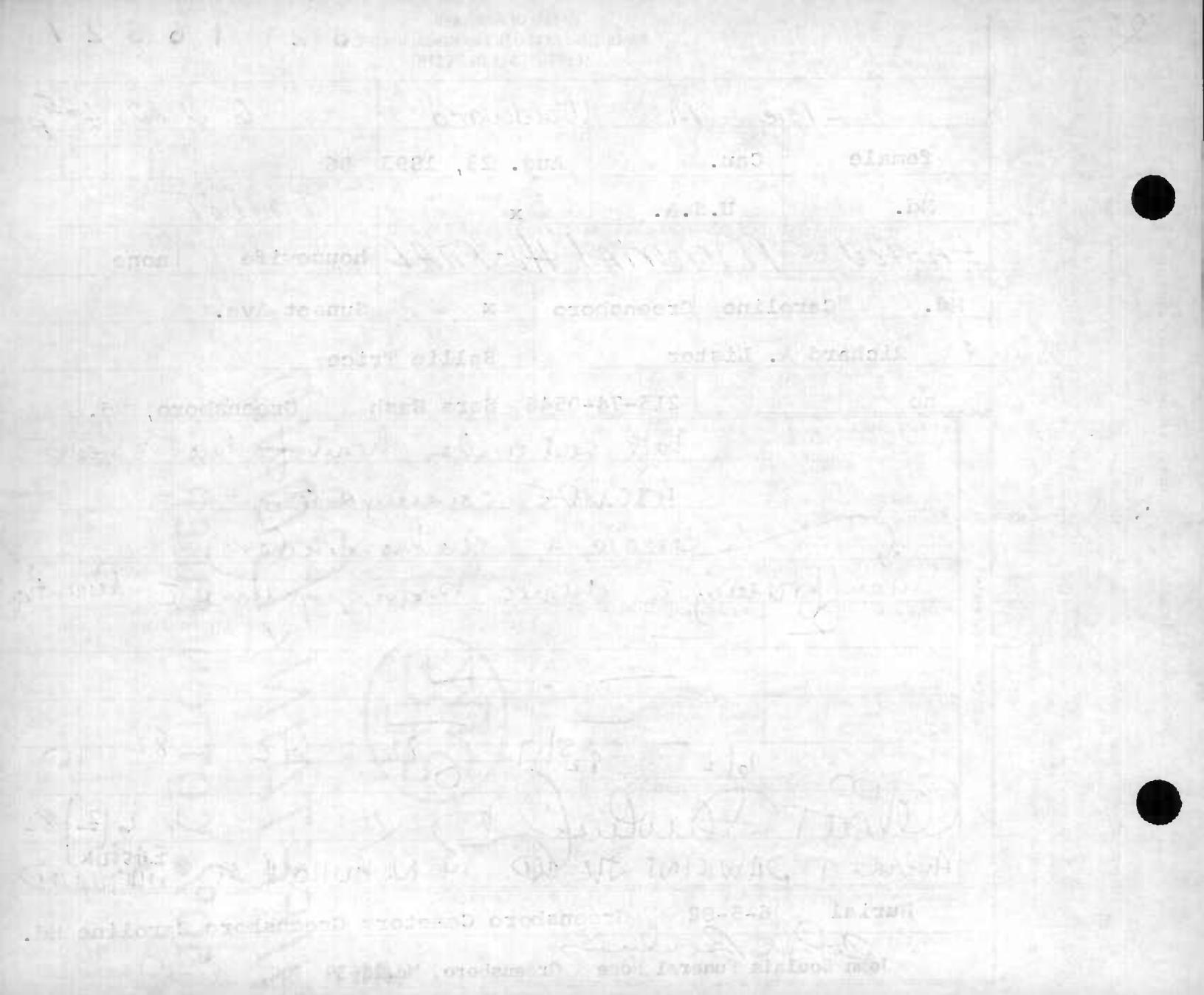
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1B is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	6	5	2	7
												REG. NO.						
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 6:25 PM						
Elsie M Woodward									6 2 82									
3 SEX female			4 RACE Cau.			5. DATE OF BIRTH MONTH Aug. 23, 1895			6. AGE (IN YEARS LAST BIRTHDAY) 86			IF UNDER 1 YEAR MONTHS YRS	IF UNDER 18 MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.						
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY none									
11a. STATE Md.			11b. COUNTY Caroline			11c. CITY OR TOWN Greensboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Sunset Ave.						
14. FATHER'S NAME Richard A. Lister						15. MOTHER'S MAIDEN NAME Sallie Trice												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-74-0546			17. INFORMANT Sara Eash			ADDRESS Greensboro, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) left ventricular heart failure			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASCVDF coronary artery			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks									
Conditions, if any, which gave rise to immediate cause for stating the underlying cause lost			(b)			(b)												
			DUE TO, OR AS A CONSEQUENCE OF Disease + cerebral vascular.)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I injury to brain & chronic brain syndrome & dementia																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) —												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6/2			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			6/2 82									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6/2 82 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			22b. SIGNATURE Albert T. DAWKINS JR. MD.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			6/2 82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert T. DAWKINS JR. MD.			22e. ADDRESS 14 N. HuRST ST						EASTON MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-5-82			23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery			23d. LOCATION CITY OR TOWN Greensboro			COUNTY Caroline STATE						
24. FUNERAL DIRECTOR NAME John E. Boulais			ADDRESS John Boulais Funeral Home			25a. DATE REC'D. BY REGISTRAR Greensboro, Md. 21650 1982			25b. REGISTRAR'S SIGNATURE James J. Boulais									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 6 5 2 8	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Hilda				MAY	Young	June 15 1982			AM	24	1982	2 PM	
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			7. UNDER 1 YEAR			
FEMALE			NEGRO	JULY 16, 1910			71			MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
DELAWARE			U.S.A.						TALBOT				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR PRINT FOR WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
EASTON			Memorial			HOUSEWIFE			HOME				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS							
MARYLAND			TALBOT	ST. MICHAELS	XX	303 DODSON AVE							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
GEORGE HOLMES						MARY HOLMES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			215-16-8688			MILDRED E. YOUNG			303 DODSON AVE. ST. MICHAELS, Md.			6 mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2030</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) _____	
{ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>29 DEC 1981</u> , to <u>15 JUN 1982</u> , that (I) (we) last saw the deceased alive on <u>JUN 14 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
STEPHEN P. CARNEY MD.											6-15-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			EASTON, MARYLAND 21601							
STEPHEN P. CARNEY MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	
BURIAL			JUNE 18, 1982			RICHARDSON CEMETERY EASTON			TALBOT MD.			STATE	
24. MEDICAL DIRECTOR			ADMITTED			DATE REC'D. BY REGISTRAR			REGIST.				
Stephen E. Leonard, St. Michaels, Md.			JUN 24 1982										

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